“Common Definitions” in Mental Health Science

Landscaping report

Created by Sangath | Commissioned by Wellcome

Project Context

The progress of mental health research relies on an evidence base that is useable. This includes the ability to find and synthesise existing knowledge to help understand what is already known about a specific topic or question. Finding and collating research, or communicating about it, often relies on shared terms and meaning. Many frequently used terms do not have clear, consensus definitions or criteria informing their use, or mean different things in different contexts. Where this is not recognised, it hampers our collective understanding.

By commissioning this project, Wellcome hoped to gain a better understanding of:

- where lack of consensus on particular terms is holding back research the most
- the nature of consensus (or lack of consensus) surrounding each of these terms
- the feasibility and utility of reaching further consensus for particular, priority terms

We hope this narrative report, delivered by Sangath, in partnership with GMHPN, outlines some of the complex landscape of consensus definitions in mental health research and practice, continues and builds on conversations about what the field might need, and starts to surface areas where further efforts might best be placed.

Role of Wellcome within the commission

Wellcome commissioned this landscaping work. This means they developed the original specification of the project and appointed a supplier, through a competitive procurement process, to deliver it.

Contents

1. Abbreviations

Abbreviation	Full Form
5-HT2A receptor	5-hydroxytryptamine receptor 2A
ACE	Adverse Childhood Experiences
ACNP	American College of Neuropsychopharmacology
AFR	WHO Africa region
AMR1	WHO North America (Canada and USA) region
AMR2	WHO Central and South Americas region
ANCP	American College of Neuropsychopharmacology
APA	American Psychological Association
ARMS	At-risk mental state
BAI	Beck Anxiety Inventory
BAP	Brief Action Planning
BDI-II	Beck’s Depression Inventory II
BDRS	Bipolar Depression Rating Scale
BLIP	Brief, Limited, Intermittent Psychotic Episodes
BPRS	Brief Psychiatric Rating Scale
CAARMS	Comprehensive Assessment of At-Risk Mental States
CANMAT	Canadian Network for Mood and Anxiety Treatments
CDRS-R	Children's Depression Rating Scale-Revised
CGI	Clinical Global Impression
CGI-BP	CGI-Bipolar Scale
CGI-S	Clinical Global Impression Scale-Severity
CHIME	Connectedness, Hope, Identity, Meaning, and Empowerment
CHR	Clinical High Risk
CRS	Clozapine-resistant schizophrenia
DSM	Diagnostic and Statistical Manual of Mental Disorders
DSM III	Diagnostic and Statistical Manual of Mental Disorders, Third Edition
DSM IV	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
DSM V	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
DSM-III	The Diagnostic and Statistical Manual of Mental Disorders, Third Edition
DUP	Duration of untreated psychosis
EMA	European Medicines Agency
EMR	WHO Eastern Mediterranean Region
EPA	European Psychiatric Association
EPI	Early Psychosis Intervention
EUR	WHO European region
FAST	Functioning Assessment Short Test

FDA	Food and Drug Administration
FEP	First-Episode Psychosis
FROGS	Functional Remission of General Schizophrenia
GAD-7	Generalised Anxiety Disorder 7-item
GAF	Global Assessment of Functioning
GAS	Global Assessment Scale
GSRD	European Group for the Study of Resistant Depression
HAM-A	Hamilton Anxiety Rating Scale
HAMD/HAM-D17/HRSD	Hamilton Depression Rating Scale
HDRS	Hamilton Depression Rating Scale
HES	Hospital Episode Statistics
HICs	High-Income Countries
HSR Network Model	Hybrid Symptom-and-Resilience-Factor Network Model
HiTOP	Hierarchical Taxonomy of Psychopathology
ICD 11	International Classification of Diseases, 11th Revision
ICD-10	International Classification of Diseases, Tenth Revision
ICF	International Classification of Functioning, Disability and Health framework
IPAP	International Psychopharmacology Algorithm Project

ISBD	International Society of Bipolar Disorders
LIFE	Longitudinal Interval Follow-up Evaluation
LMICs	Low- and Middle-Income Countries
MADRS	Montgomery–Åsberg Depression Rating Scale
MADRS-S	Montgomery–Åsberg Depression Rating Scale - Self-rated
MDD	Major Depressive Disorder
MDE	Major Depressive Episode
MOHS	Ministry of Health Singapore
MRS	Mania Rating Scale
NCCSDO	National Co-ordinating Centre for Service Delivery and Organisation
NDIS	National Disability Insurance Scheme
NHS England	National Health Service
NICE	National Institute for Health and Care Excellence
NIH	The National Institutes of Health
NIHR	National Institute for Health Research
NIMRC	National Medical Health and Research Council
NMHRC	The National Medical Health and Research Council
PANSS	Positive and Negative Syndrome Scale
PANSS-PN	PANSS-Positive Negative

PANSS-T	PANSS-total score
PHQ-9	Patient Health Questionnaire
PSR	Psychiatric Status Ratings
PSWQ	Penn State Worry Questionnaire
PTSD	Post-Traumatic Stress Disorder
Q-LES-Q	Quality of Life Enjoyment and Satisfaction Questionnaire
QoL	Quality of Life
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RCT	Randomised Controlled Trial
RSWG	Remission in Schizophrenia Working Group
SAMHSA	Substance Abuse and Mental Health Services Administration
SANS	Scale for the Assessment of Negative Symptoms
SAPS	Scale for the Assessment of Positive Symptoms
SAS-SR	Social Adjustment Scale-Self Report
SCID-I	Structured Clinical Interviews for DSM
SDS	Self-rating Depression Scale
SEAR	WHO Southeast Asian Region
SIPS	Structured Interview for Prodromal Syndromes
SOFAS	Social and Occupational Functioning Assessment Scale

STAR*D study	Sequenced Treatment Alternatives to Relieve Depression
TRA	Theory of Reasoned Action
TRD	Treatment Resistant Depression
TRIP	Treatment Response and Resistance in Psychosis
TRM	Treatment Resistant Mania
TRS	Treatment-resistant schizophrenia
TRSM	Thase and Rush Staging Model
UHR	Ultra-high risk
UTRS	Ultra-treatment resistant schizophrenia
WFSBP	World Federation of Societies of Biological Psychiatry
WHO	World Health Organisation
WHODAS	World Health Organisation Disability Assessment Schedule
WPR	WHO Western Pacific region
YMRS	Young Mania Rating Scale

2. About the Team

The Common Definitions in Mental Health Science (CDMHS) project was commissioned by Wellcome. It is a collaboration between Sangath's Addictions and Related-Research Group and the Global Mental Health Peer Network (GMHPN). The project was led by:

Prof. Richard Velleman, Principal Investigator (Sangath)
Prof. Abhijit Nadkarni, Co-Investigator (Sangath)
Claudia Sartor, Co-Investigator (GMHPN)

The project team (Sangath unless otherwise specified):
Soumya Singh, Project Manager
Dhriti Agarwal, Researcher
Payal Khatore, Researcher
Ankita Kandolkar, Admin
Aradhya Sharma, Research Intern
Arya K Suresh, Research Intern
Edwin Mutura, Communications (GMHPN)

Advisory Governance

This commission was guided by two advisory boards; a mental health research and clinical (MHRC) advisory board and GMHPN's mental health lived experience (MHLE)[1] advisory board.

The MHRC advisory board members included Ricardo Araya (South America), Claudi Bockting (Europe), Dristy Gurung (South Asia), Matt Muijen (Europe), Shekhar Saxena (North America), Mary O Hagan (Australia), and Victor Ugo (Africa).

The MHLE board members included Arnold Agba (Africa), Constance Mabia (Africa), Deborah Omage (Africa), Fahmida Akter (South Asia), Keshnie Mathi (Africa), Lucia De Sola (South America), Muskan Lamba (South Asia), Natasha Njafuh (Africa), Nur Yanayirah (Southeast Asia), Parth Sharma (South Asia), Sandra Ferreira (Africa), Sharline Cordner (Africa), Wariimi Karingi (Africa), and Zbynek Robock (Europe).

Liaison with Wellcome

The project team met regularly with a team from Wellcome to discuss progress, consult over any issues, and receive comments on drafts of consultation materials and of reports. The Wellcome team included: Sophie Chung, Niall Boyce, Meghna Khatwani and Sophie Ul-Haq.

1 Lived Experience Expertise (LEE): Distinguished from the term Person With Lived Experience (PWLE) in that a Mental Health Lived Experience Expert (MHLE) or a person with LE expertise, as well as having had personal experience of MH problems, is someone who has the systemic knowledge/expertise to use their collective experiences to shape or influence research or policy more broadly.

3.

Executive Summary

Executive Summary

> No concept can be defined once and for all: every concept of science requires constant purging to keep it operationally healthy."
> *SS Stevens, 1975* [2]

The Common Definitions in Mental Health Science (CDMHS) project, commissioned by Wellcome, aimed to landscape inconsistencies in the definitions of key mental health terms commonly used in research. This report provides a landscaping of existing consensus papers and the various definitions of selected mental health terms, along with opinions and tensions over whether or not universal agreements are appropriate or feasible. The findings are based on an extensive review of academic and grey literature and global expert consultations.

We used multiple methods to ascertain our findings.

Phase I was aimed at shortlisting the mental health terms that constitute the focus of this landscaping. In this phase, we started with eleven mental health terms which had already been identified via internal consultations at Wellcome, and used these as the basis for our consultations, We conducted 25 in-depth interviews with mental health and lived experience experts; and a global online survey with lived experience experts, researchers, mental health professionals, and other medical practitioners (434 individuals consented to the survey; 322 completed demographic information and ≥1 question from the survey; 140 completed all survey questions. We obtained useable information from n=322).

We concluded this phase by selecting 15 shortlisted terms. These were selected from the initial eleven with the addition of 104 further terms suggested by consultees, by triangulating data from the in-depth interviews and the survey responses, and by prioritising terms that had: high impact on research, low-moderate current consistency, high feasibility, significant interest from service users, and relevance to early intervention. These 15 terms were then shared with Wellcome as recommendations within an Interim Report and then mutually agreed as the ones for which the definitional landscape was to be reviewed.
These 15 terms are[3]: Prodrome, First Episode, Drug-induced, Trauma/Trauma-informed Care, Comorbidity, Early Intervention, Compliance, Adherence, Treatment Resistance, Relapse, Remission, Recovery, Resilience, Functional Impairment/Functional Outcomes, Mechanism. Phase II aimed to understand the landscape of definitions for each selected term. We reviewed academic literature, mental health guidelines, international repositories, and dictionaries to determine the existing consensus definitions and the recent use of these terms in mental health research. We also held consultations with both mental health and lived experience experts across the six World Health Organisation (WHO) regions to understand the gaps and variations emerging from desk-based research and to identify whether further work on consensus would be beneficial. Based on our findings, we recommend that further consensus work is undertaken on several of these terms to improve research and clinical practice. Our assessment considers the current extent of consistency in how these terms are used within research publications, expert opinions, and the feasibility of further consensus building.

2 Stevens, S. S. (1975). "Psychophysics." In Stevens, S. S. (Eds.), Handbook of Psychophysics. New York: Wiley.
3 The ordering was chosen to represent the journey: prodrome, first episode, drug-induced, trauma, comorbid represent the early stages of understanding the conditions or their causes; early intervention through to functional outcomes represent issues related to interventions and progression through the conditions; mechanisms is an outlier.

The following eight terms (listed alphabetically) were identified as being a high priority for consensus building:

- **Adherence/ Compliance** would benefit from a consensus, particularly surrounding the socio-cultural factors associated with non-adherence that are often missed. While researchers understand the core concept, operational definitions differ. This is especially true with psychological interventions, where adherence lacks clear measurement criteria. This is often a term which people with lived experience find stigmatising.

- **First Episode** is a term where further consensus is needed, particularly to address areas of disagreement such as variability in duration, over-reliance on contact with treatment services, initiation versus successful completion of treatment, and history of use of medication. Existing definitions are restricted by the use of treatment contact as a proxy, particularly in contexts where services may not be available. The term 'first episode' itself can be vague and potentially misleading, with some agreement that a term such as 'recent onset' would be clearer.

- **Functioning/Functional Outcomes-Impairments** is measured across various domains (social, cognitive, occupational), and while achieving a universal definition may be difficult, some agreement on a broader framework on functioning (i.e. agreeing key domains) and making functional outcomes a primary objective would enhance research comparability.

- **Recovery** presents unique challenges because views vary among researchers, practitioners and those with lived experience; some distinguish between clinical recovery (symptom-based), functional recovery (recovery in various domains of functioning), and personal recovery (holistic well-being, autonomy, and quality of life). However, defining functional and personal recovery remains difficult due to cultural differences and subjective experiences. Despite these challenges, refining recovery definitions could improve research measurements and optimise treatment outcomes.

- **Relapse** is frequently reported in research on psychosis, depression, and anxiety, but inconsistencies exist in threshold and timeframe definitions and the use of measurement tools. For example, some studies define relapse based on the return of symptoms (using varied cut-offs), while others rely on proxy measures (e.g., hospitalisation), which may not apply in all healthcare settings. Given the central role of relapse in clinical trials and treatment evaluations, defining it more clearly would enhance consistency in both research and practice.

- **Remission** is a term widely but inconsistently utilised in research; remission generally refers to symptom reduction, but there is significant divergence in its application. The description of functioning as an outcome, secondary to symptom remission, is also highly contested by people with lived experience. Given remission's central role in clinical trials and treatment evaluation, defining it more clearly would enhance consistency in research and practice.

- **Treatment Resistance** is a term requiring refinement. Experts agree that treatment resistance indicates a suboptimal response to standard therapies, but definitions vary regarding treatment duration, adherence criteria, and the inclusion of psychological interventions. Researchers have made considerable progress in defining treatment resistance for depression and psychosis, but discrepancies endure.

People with lived experience find this term stigmatising; many attribute the lack of response to a service user shortcoming, rather than being attributed to the poor compatibility between the condition and the treatment.

• Finally, although Trauma is a low priority term (see below), **Trauma-Informed Care** follows structured principles, facilitating the development of a widely accepted consensus framework.

The following seven terms (listed alphabetically) were identified as being a low priority for consensus building. This is because these terms have relatively fewer inconsistencies, or the inconsistencies which exist are not reported as limiting research and hence do not require immediate standardisation.

• **Comorbidity,** while conceptually agreed upon as the coexistence of two or more conditions, it is used in varying ways across disciplines and contexts. Some researchers treat comorbid conditions as completely independent, while others view them as interrelated or hierarchical. However, these variations did not seem to impede research progress, and the general concept remains well understood.

• **Drug-induced Conditions** such as drug-induced psychosis, anxiety, and depression, are already defined in DSM and ICD classifications. While critiques exist regarding these classifications, particularly regarding implied causality, these terms are widely accepted by researchers and clinicians. Given this, additional consensus-building efforts are not a priority.

• **Early Intervention** has a broadly accepted definition, although confusion arises when it is used in place of prevention and early-life interventions. Our findings indicate that this does not significantly hinder research progress, so additional efforts are not a priority.

• **Mechanism** encompasses a term where consensus efforts may be challenging or even impossible, because it is used across a very wide range of disciplines and scientific frameworks.

• **Prodrome** is widely used in psychosis research, particularly in identifying individuals at ultra-high risk (UHR) or clinical high risk (CHR) for developing psychosis. The term is widely considered retrospective and pessimistic; LE experts and others have concerns regarding stigmatisation in many areas (screening, clinical diagnosis, insurance, education, employment, legal consequences, community-based mental health settings, and within communities with low access to awareness on mental health). It was acknowledged that there is a shift toward the CHR framework and further consensus building on a retrospective concept was unlikely to add value.

• **Resilience** is a term where consensus efforts may be challenging and premature, as it is widely used across multiple disciplines, each applying different interpretations.

• **Trauma** encompasses a term where consensus efforts may be challenging and premature, due to its use across diverse disciplines, including psychology, psychiatry, and social sciences, with many differing interpretations.

Some of the key issues that emerge across the landscape are as follows:

a) variability in operationalisation, even where there is broad agreement on a definition

b) low adoption of consensus definitions

c) Western-centric bias in existing definitions and consensus efforts that impact contextualisation and relevance in global contexts

d) inconsistent terminology, with the use of different words to mean the same thing

e) semantic concerns about terms that carry unintended connotations

f) limited stakeholder representation, particularly from lived experience experts, to contribute perspectives; and the impact this has on wider conceptual understanding.

> Words are not just words — they are power. Who gets to define mental health terms decides who gets care, who gets discharged, and whose experience is invalidated."
> *-–MH expert, workshop consultation* [4]

4 The quotes highlighted throughout the document are derived from our interviews and consultations.

4.

Introduction

Introduction

The immense volume of available mental health research is difficult to navigate, understand, and synthesise, particularly across the vast range of relevant individuals, organisations, and systems. One of the key challenges underlying this issue is the inconsistent use of mental health terminology. Sometimes, different terms are used to mean the same thing; sometimes, the same terms may be used with vastly different meanings. These issues limit effective research and the translation of research findings into practice, both essential for the development of new treatments and the improvement of existing treatments.

The CDMHS project commissioned by Wellcome aims to map the existing consensus landscape for mental health terms in anxiety, depression, and psychosis research and translation

Aims

Identify priority mental health terms used in anxiety, depression, and psychosis which may benefit most from greater consensus definition in the next five years.

Clarify the degree (or lack) of consensus which exists for each of the prioritised terms.

Assess the feasibility of developing consensus definitions for selected mental health terms.

FIGURE I

4.1 Conception and Scope

Eleven mental health terms with varying definitions in different contexts were identified via internal consultations at Wellcome. These were as follows:

- Prodrome
- First Episode
- Drug-Induced
- Treatment Resistance
- Adherence
- Comorbidity
- Remission
- Relapse
- Recovery
- Interaction
- Mechanism

This report outlines the process of revising and expanding this list to fifteen terms, based on international mental health and lived experience experts' inputs, and mapping out their definitional landscapes.

It was not within the scope of this report to create new definitions but rather to evaluate the existing definitions and establish where greater clarity may prove useful for the research and wider communities. It was also not within the scope of this project to identify common definitions for diagnostic mental health terms such as depression, anxiety, and psychosis.

5.

Methodology

Methodology

We followed a two-phased approach to develop the definitional landscape of selected mental health terms and identify tensions in the common definitions space within anxiety, depression, and psychosis.

5.1 Phase I (identifying priority mental health terms to constitute the focus of this landscaping)

Phase I utilised a mixed-methods approach to identify the priority mental health terms that constitute the focus of this landscaping. This involved conducting interviews with key stakeholders and canvassing via a global online survey. The interviews and survey were used to establish the appropriate priority terms by answering four key questions as follows:

- **Consistency** — How consistently is each of the eleven terms currently defined and used? (higher the consistency, lower the priority).

- **Impact** —To what degree does the lack of consensus on each of the eleven terms limit mental health research? (higher the impact, higher the priority).

- **Feasibility** — What is the feasibility of achieving consensus on each of the eleven terms? (higher the feasibility, higher the priority).

- **Additional terms** — Are there any additional terms to be added to the landscaping evaluation based on their consistency, impact, and feasibility?

Interviewees consisted of 12 research and clinical experts with 10+ years of experience within anxiety, depression, or psychosis, and with experience in early interventions, global and/or region-specific expertise, and from diverse disciplinary backgrounds including psychiatry, psychology, social work, and neuropsychopharmacology; and 13 lived experience experts within GMHPN who have lived and professional or leadership/advocacy experience with anxiety, depression, or psychosis. These selection criteria were used to ensure expertise in defining key terms. A total of 14 (56%) participants were women and 10 (40%) were men; 11 (44%) were from the European region (EUR), 9 (36%) from South Asia, 8 (32%) from the Africa region (AFR), 3 (12%) from North America (Canada and USA, AMR1), 2 (8%) from Central and South Americas (AMR2), and 1 (4%) from the Western Pacific region (WPR). In total, 17 (68%) identified as researchers, 14 (56%) as lived experience experts, 10 (40%) as global mental health experts, 8 (32%) as psychiatrists, and 2 (8%) as other practitioners. There were 12 participants with specific expertise: international mental health (1), neuroscience (1), clinical psychology (1), clinical social work (1), nursing (1), public health practice (1), human rights advocacy (1), social work and policy (1), epidemiology (1), and counselling (1).

The global survey was conducted online; participants were recruited via snowball sampling through leading mental health institutions and via our advisory boards, and through an open call on social media, and included lived experience experts, researchers, mental health professionals, and other medical practitioners. A total of 434 individuals consented to participate in the survey; 322 provided demographic information and answered and at least one key question from the survey; and 140 completed all the survey questions. We obtained useable information from n=322.

Women comprised 281 (68%) participants, 95 (29%) identified as men, 7 (2%) as non-binary, and 2 (1%) did not disclose their gender. The majority of participants were from the Southeast Asian Region (SEAR) (n=156, 48.6%), followed by the EUR (n=64, 19.9%), the AFR (n=48, 15%), AMR1 (n=35, 10.9%), the Eastern Mediterranean Region (EMR) (n=9, 2.8%), the WPR (n=8, 2.5%), and AMR2 (n=6, 1.9%). Regarding disciplines, 141 individuals (43.8%) identified as researchers, 87 (27%) as lived experience experts, 70 (21.7%) as practitioners, and 67 (20.8%) as working in global mental health. Other notable fields included clinical psychology (n=51, 15.8%), other psychology (n=31, 9.6%), psychiatry (medical practitioners; n=33, 10.2%), international mental health (n=26, 8.1%), other medical practitioners (n=15, 4.7%), and others (n=59, 18.32%).

Following the interviews and the survey, 104 different additional terms were suggested for inclusion in the landscaping. These were each reviewed for frequency and internal discussions ensued to decide which, if any, would be included. At the conclusion Phase I, a list of 15 priority terms was established, shown in Table 5.1 below. The terms were selected by prioritising terms that had: high impact on research, low-moderate current consistency, high feasibility, significant interest from service users, and relevance to early intervention. These 15 terms were then shared with Wellcome as recommendations within an Interim Report to them, discussed between the research team and Wellcome within one of our regular meetings, and then mutually agreed as the ones for which the definitional landscape was to be reviewed.

Table 5.1 Terms selected for landscaping based on interviews and survey results

Priority	**Definitional terms**					
High priority	Recovery	Treatment resistance	Remission	Mechanism		
Moderate priority	Relapse	Adherence	Prodrome	First Episode	Drug-induced	Co-morbidity
Low priority (excluded)	Interaction					
Additional terms emerging from interviews/ survey						
Resilience	Early intervention	Compliance	Trauma/ Trauma-informed		Functional outcomes/ Functional impairment	

5.2 Phase II (analysis of the definitional landscape)

Phase II reviewed the existing consensus or definitional evidence for each of the selected priority terms, through literature reviews, expert consultations, workshops, and dictionary analyses. Global consultations with experts from the six WHO regions assisted in identifying, outlining, and evaluating the current degree of consensus for these priority clinical concepts. This determined whether consensus would be beneficial and clarified the tensions around common definitions that required resolution. The data sources utilised in Phase II are summarised in Table 5.2, below.

Table 5.2 Summary of data sources utilised in Phase II

Source	Input	Output
Academic literature	966 papers on the definition, conceptualisation, and consensus of the selected terms, and other related issues[5].	Identification of terms for which consensus definitions do not exist Identification of terms for which consensus definitions do exist Identification and analysis of existing consensus guidelines, areas of agreement and disagreement in the definitions, use of definitions in research and practice
Grey literature	73 national and international guidelines and grey literature materials	Identifying how treatment guidelines define selected terms
Dictionaries	14 dictionaries appraised for current definitions	Dictionary definitions of terms
Workshop consultations	67 participants from 6 WHO regions	Addressing questions arising from the academic and grey literature reviews, and the reviews of dictionaries

An academic literature review was performed in two parts. Searches were conducted using PubMed and Google Scholar to identify existing consensus guidelines or literature appraising common definitions. If publications related to existing consensus or common definitions were identified, these were reviewed to understand the landscape (consensus or definition), ascertain which stakeholders had developed the consensus definitions, guidelines, and/or statements, in which region/country they had been developed, under which conditions they were employed, how (and how often) they were used, which disciplines/fields/subfields did they most relate to, what were the critiques, and whether some were used more than others (measured via citations or other metrics of uptake), and why. If publications related to existing consensus or common definitions were not identified, a wider review of recent systematic reviews and/or recent trials was undertaken, to examine what was reported regarding definition or conceptualisation of the term in question; how the term was described or used in recent research; and what gaps existed regarding definition across conditions, regions, stakeholders, time points, and contexts. The inclusion and exclusion criteria and search strategy are appended (Appendix 12.1).

5 This is a larger number than that shown in Table 5.3 below. This is because the 966 includes many further papers which were not specific solely to the 14/15 terms in question, some of which are referred to in other Chapters.

Table 5.3 Number of consensus guidelines, systematic reviews or trial papers reviewed per term

Term	No. of academic papers	No. of grey literature items[6]
Adherence/ Compliance	27 (3.0%)	11 (5.3%)
Comorbidity	42 (4.7%)	9 (4.4%)
Drug-Induced	48 (5.4%)	28 (13.6%)
Early Intervention	61 (6.9%)	10 (4.9%)
First Episode	57 (6.4%)	15 (7.3%)
Functioning, functional outcome/impairment	43 (4.8%)	11 (4.8%)
Mechanism	30 (3.4%)	3 (1.5%)
Prodrome	126 (14.2%)	15 (7.3%)
Recovery	112 (12.6%)	20 (9.7%)
Relapse	66 (7.4%)	17 (8.3%)
Remission	99 (11.1%)	23 (11.2%)
Resilience	36 (4.0%)	12 (5.2%)
Trauma and Trauma-Informed Care	41 (4.6%)	17 (8.3%)
Treatment Resistance	102 (11.5%)	28 (13.6%)
Totals	**890**	**219**

A grey literature review was performed using TRIP and Google Scholar to identify national and international treatment and regulatory guidelines (e.g. National Institute for Health and Care Excellence, WHO guidelines), blogs, and patient information leaflets (Appendix 12.5).

A dictionary review was performed to identify how each of the terms is currently defined. A list of the dictionaries reviewed is appended (Appendix 12.6).

The number of consensus guidelines, systematic reviews and trial papers reviewed per term is shown in Table 5.3, above.

Following completion of the initial desk-based research, seven consultation workshops were organised, each focusing on interrelated priority terms; 67 people participated in the consultations although some individuals participated in more than one session. Participants were international experts in mental health research, clinical practice, or lived experience from throughout the six WHO regions. Workshop timings were coordinated to take regional time zones into consideration and ensure maximum participation. A small number of participants who were unable to attend a workshop responded to our semi-structured questions via email. In each semi-structured workshop, the findings garnered from the literature reviews and the gaps identified during the process were discussed to facilitate a deeper understanding and to elucidate whether consensus would be beneficial.

All interviews and workshops were recorded and transcribed for analysis.

6 This includes guidelines, dictionary definitions, and other grey literature. For dictionary definitions, while we looked at 14 dictionaries for each term, this number only includes those that actually defined the term. We found no guidelines which examined 'mechanism'. The amount of grey literature is larger than the number of guidelines, dictionaries etc shown in Table 5.2 as many items related to more than one term.

6.

Overarching Issues

Overarching Issues

Following the completion of Phase II, several overarching issues affecting consensus and operationalisation of mental health definitions were identified.These are listed immediately below, and then each one is examined in more detail in the subsequent sections of this chapter.

- Issues with operationalisation
- Variability despite consensus — low adoption of the consensus definition
- Western/HIC bias
- Psychological Interventions - Where do they fit in?
- Might 'Frameworks' sometimes be more useful than 'Definitions'?
- Interchangeable use of terms
- Interdependence of terms
- Semantics
- Under-examination of functioning and under-consideration of functional outcomes and functional impairments
- Stakeholder representation

6.1 Issues with Operationalisation

While there is agreement on the broader definition of several terms including remission, relapse, and adherence, the operationalisation of these terms is highly variable across studies, along a number of domains, including measures, cut-offs, durations, and the alignment of definitions.

Careful consideration of these variations is vitally important since the data obtained are often used in the compilation of national, regional, and global figures. Differences in data collection methods across research groups can result in less accurate data synthesis and meaningful comparisons become moot. For example, a review of recovery in psychosis revealed that the prevalence of recovery was higher in North America compares to other regions, which showed a lower pooled prevalence recovery rate [1]. However, none of the North American studies applied a stringent 2-year criterion for defining recovery, whereas eight studies (32%) from other regions did, suggesting that the operationalisation of the definition contributed to the observed differences. The implications of differing criteria stringency were also found to apply to other terms (e.g., remission and relapse).

6.1.1 Variation in the use of measures

Variation in the use of measures represents a key area of concern because it leads to inconsistent treatment guidelines, inaccurate prevalence estimates, and issues with comparability. For example, adherence to treatment plans or medication regimens can be assessed using several different instruments. Some studies use direct measures, such as the Medication Adherence Rating Scale (MARS)[7], while others rely on self-reports or proxy measures like pill counts or medication logs. Research groups using standardised measures frequently use different measures, which further reduces the comparability across studies. For example, when conducting depression research, both the Hamilton Depression Rating Scale (HAMD)[8], and the Montgomery–Åsberg Depression Rating Scale (MADRS)[9] are accepted and widely used.

7 For the full list of abbreviations, refer to section 1, page 3.
8 For the full list of abbreviations, refer to section 1, page 3.
9 For the full list of abbreviations, refer to section 1, page 3.

Often, research groups choose different measurement instruments than those recommended in consensus statements. For example, consensus criteria relating to schizophrenia remission specify the use of eight items from the Positive and Negative Syndrome Scale (PANSS) tool, yet many research studies use different measures such as PANSS total or PANSS Positive and Negative.

There are several initiatives underway to promote the congruence of common measures in mental health research [2] and funders such as Wellcome have already recommended certain standard measures for child and adult depression and anxiety, and adult functioning (https://wellcome.org/grant-funding/guidance/common-metrics-mental-health-research). Nevertheless, much more needs to be done to increase standardisation.

6.1.2 Variation in the cut-offs applied when using the same measures

In some cases, researchers use the same tools but apply different cut-offs. For example, to assess remission in depression many use the Hamilton Depression Rating Scale (HAMD), however, the cut-off to determine remission differs between studies, being reported as ≤6, ≤7, or ≤8 [3]. Some remission criteria require a patient to display virtually no symptoms, whereas others allow for mild to moderate impairment. To measure relapse in depression, the Montgomery–Asberg Depression Rating Scale (MADRS) is often used. We found that the score used to determine relapse ranged from ≥18 to ≥22 between studies [4]. When measuring adherence in research trials, some stated that the target was met if patients followed the plan/took their medication >70% of the time, while for others it was >80%. Similarly with functioning, many use the Global Assessment of Functioning (GAF), but cut-offs at which a patient is determined as 'functioning well' vary between 60 and 80 [5].

There may be context-dependent reasons for research groups to select different cut-offs, but reasons are rarely documented. The validation of different cut-offs in different contexts or with different populations would be helpful to better understand such variations.

These issues remain even where consensus definitions are agreed. For example, the 'Remission in Schizophrenia Working Group' (RSWG) [6] defines remission as a score of ≤3 on eight specific PANSS items, whereas a recent Korean Consensus group suggests a PANSS score ≤2 for both positive and negative items [7]. The same scale is used to assess relapse in schizophrenia; however, we found suggestions including a 10-point increase in the PANSS score, a 12-point increase in the PANSS score, and a ≥25% increase in the total PANSS score, each of which is meant to indicate relapse [8,9].Even the proxy indicators (e.g. hospitalisation) used to determine relapse differ in their cut-offs. Sometimes hospitalisation for any reason is accepted as an indicator, with no distinction made between hospitalisation for mental health reasons versus childbirth, an operation, or an unrelated physical condition [10]. Conversely, some restrict their use of hospitalisation as an indicator, to psychiatric-related admissions [11].

As stated, the use of such differing cut-offs means that aggregating data to determine recovery status becomes impossible, representing a major problem for furthering research and practice.

6.1.3 Duration

Variations in duration, the timeframe within which a construct should be measured, also pose issues of comparability and validity. While some definitions state that remission must last at least 12 months [7] in order to be recognised as such, others set the duration at 3–6 months [6,12]. Similarly, a 7-day minimum criterion is recommended for defining relapse, but many studies report relapse within a much shorter period of 1–2 days [13]. Such a short duration may not reflect a 'true' relapse but merely a temporary or transient deterioration (although, of course, this depends on the definition of relapse being used). Furthermore, some studies on schizophrenia recovery report duration criteria ranging from 6 months to 2 years [6,14].

6.1.4 Operationalisation — Overall

Moncrieff and colleagues highlight the increasing variability in the operationalisation of relapse. They state: *"Since 1990, there are almost as many definitions as trials"* [13]. This holds true for studies on remission as well, where multiple definitions encompass different tools, cut-offs, and durations.

This suggests that 'the devil is in the detail'. As stated, with many of the terms examined within this project, there is agreement on the broad definition of some terms based on concept and meaning. However, problems arise when researchers or research groups operationalise that concept, causing the issues outlined to come into play.

It would be beneficial to develop agreed operational criteria regarding measurement issues such as cut-offs and duration, as well as identifying the preferred standardised measuring tools.

As workshop participants argued, it is necessary to avoid overly rigid operationalisations, which might exclude individuals with fragmented or sub-threshold symptoms or fluid diagnoses early in the course of their illness. However, currently there is an absence of agreed operationalisations, which impedes progress.

The Wellcome and National Institute of Mental Health co-chaired initiative referred to above and the work of the International Alliance of Mental Health Research Funders (IAMHRF) (https://iamhrf.org/projects/driving-adoption-common-measures) including medical journals, and data measurement experts committed to adopting common measures in mental health science, will all help to accelerate this agenda.

6.2 Variability Despite Consensus — Low Adoption of Consensus Definitions

Even when consensus efforts have been made to define certain terms, adoption remains inconsistent. One of the more widely adopted consensus criteria is the RSWG definition of remission in schizophrenia; however, many studies follow the consensus partially or not at all. Our consultation workshops revealed that cultural variability in the understanding of remission may explain some of this, and that different systems (e.g., DSM vs. ICD) are followed in different countries which impact on how consensus criteria are adopted. Further research on cross-cultural variations and the development of culturally attuned remission measures would be helpful. Some participants also stated that researchers might simply not be privy to the consensus definitions that have been proposed.

Treatment resistance also sees low adoption of consensus definitions. Multiple Delphi studies and decades of research have sought to define treatment resistance, and while some convergence is emerging, a single universal definition has yet to be widely adopted, and uptake of any of the existing definitions is low.

This raises the question: What hinders the adoption of consensus definitions in mental health research? While the actual reasons for this low uptake may only be known to individual researchers, our desk-based research and our consultations have highlighted certain possibilities.

All of the following were suggested in workshops and/or individual interviews, when this question was posed, and there was general agreement that all were feasible possible reasons (and certainly this list is not exhaustive):

- Expert-developed definitions fail to capture the realities of most research and clinical settings.

- There is lack of clarity regarding the most reliable or valid definition.

- There is a general lack of focus on definitions when conducting mental health research.

- Researchers avoid using consensus definitions because they believe that existing definitions often lead to over-pathologisation for people with lived experience.

- The field lacks a structured framework for building strong consensus, beyond traditional methods like Delphi.

- Overly rigid definitions limit research applicability.

There was general agreement within workshops and interviews that common definitions should be facilitative rather than prescriptive. Also, as outlined above, the experts felt that further research on cross-cultural variations and the development of culturally attuned measures would be helpful; and our work strongly suggests that consensus requires development through multi-stakeholder involvement.

However, the definitional landscape remains complex, and the adoption of consensus definitions is consequently slow. There are many potential reasons for this, as outlined above. Added to these, different research groups may be entrenched in previous definitions or operationalisations; researchers may be unconvinced regarding the evidence about optimal measures, or which cut-offs are more sensitive; and lived experience experts (LEEs) may be sceptical about standardised definitions that primarily focus on symptom reduction rather than the functioning of individuals. To ensure broader adoption, definitions should reflect real-world experiences and align with the diverse ways in which people understand and navigate mental health. In the meantime, it is clear that efforts continue to redefine and re-operationalise key concepts; however, each new attempt currently adds to the large number of different definitions, instead of improving clarity.

A greater awareness about the range of measures, operationalisations, cut-offs, durations, etc., and evidence of their effectiveness in different contexts may be part of the solution, thus enabling research groups to make informed decisions about which definitions to adopt.

6.3 Western/High Income Countries (HIC) Bias

As the Tables at the start of each of the individual Definitional Landscapes demonstrate, most of the research on consensus development, appraisal of consensus statements, and appraisal of definitions originates from high-income countries (North America, Europe and Australasia). There is limited understanding of what works and why in low-income countries and non-Western settings when defining key terms; therefore, the applicability of widely used definitions in differently resourced or different cultural settings remain unclear.

It is well recognised that the adoption (or adaption) of ideas, techniques, and measures developed in HICs is not always appropriate for low-income regions, or indeed for low-resource settings within HICs. Instead, such ideas must be critiqued and examined to assess whether they can be utilised or adapted in more culturally favourable ways. In some cases, novel and more culturally relevant ideas, techniques, and measures may need to be developed for use in lower–middle income countries (LMICs) and low-resource settings. Many of the ideas implicit within the definitions we have examined create major problems when incorporated within low–resource settings.

Hospitalisation as a proxy indicator for relapse may be problematic for many reasons. Firstly, not all relapses lead to hospitalisation. Secondly, hospitalisation requires the presence of hospitals, and in many LMIC settings these are either non-existent or inaccessible to much of the population. The bed rates in low (median 1.9 beds per 100,000), lower–middle (median 6.3 beds per 100,000), and upper–middle income (median 24.3 beds per 100,000) countries are much lower on average than in HICs (median 52.6 beds per 100,000) and in the OECD (mean 62 beds per 100,000) [15]. Even if contact with mental health services is used as a proxy for hospitalisation, the differences across HICs and LICs is stark. For example, high-income countries have 20 times more beds in community-based inpatient units and 30 times more admissions; the rate of patients cared for by outpatient facilities is 40 times higher, and there are 66 times more community outpatient contacts and 15 times more mental health staff at outpatient level [16].

First episode is often defined as first treatment contact or service contact within the first five years of illness onset; however, contact with mental health services is strongly associated with the availability and accessibility of those services. According to this definition, if there are no available services, then there can be no first episode per se. Further, in high-resource settings the recognition of a first episode is often a gateway to comprehensive multidisciplinary services, particularly for psychosis. In regions with limited resources, the absence of specialised programmes and inadequate mental health awareness and services means that referral to such treatment services cannot occur.

Many of the commonly used assessment tools recommended in consensus statements are clinician-administered. In resource-constrained settings, their implementation may be impractical due to a shortage of clinicians to administer these assessments. Moreover, many of the tools and measures used do not capture the cultural and socioeconomic contexts in LMICs. Within the area of recovery, Murwasuminar and colleagues agree with the the psychosocial focus of the CHIME framework[10] [17] but they also acknowledge that it does not fully capture the diverse cultural elements that are critical to the recovery process in Southeast Asia [18].

10 The CHIME framework is outlined on page 56, in the section on Recovery. In brief, it is a conceptual framework which links five recovery processes: connectedness; hope and optimism about the future; identity; meaning in life; and empowerment.

The authors argue that the CHIME model is rooted in a Western biomedical approach which does not adequately address culture-specific factors such as spirituality, stigma, and collectivism. Case studies highlight that for many individuals with schizophrenia in the region, religious practices such as daily prayers and community involvement are central to recovery, with some incorporating these practices alongside, or in place of, medication [19].

In low resource settings, the priority may be to develop culturally appropriate ways to assess people with mental health problems prior to intervention, rather than developing consensus on definitions which are not feasible or applicable to the country in question. Equipping professionals with cultural competence training so that they can interpret symptoms more appropriately, engaging with community practitioners (including traditional healers; they are often the first contact for mental health concerns), and developing non-formal interventions led by community health workers/spiritual healers might be a better use of limited time and resources.

6.4 Psychological Interventions - Where do they fit in?

In the definitional literature, and ergo in much of the operationalisation work that has been undertaken, the primary focus is psychiatric medication. For example, most definitions of treatment resistance relate to the number and dosage of the medications administered, and/or to an individual's willingness to take the medication regularly. However, despite their importance as first-line interventions, psychological and psychosocial interventions are rarely or inadequately discussed in the definitional literature.

Similarly, the most recognised definitions and operationalisations of adherence relate to medication regimes. When psychological or psychosocial interventions are discussed, the measurement of adherence remains poorly defined. In this context, adherence is often described as attending some or all therapy sessions, although attendance does not necessarily indicate active engagement which is a prerequisite for talking therapies to be effective.

6.5 Might 'Frameworks' sometimes be more useful than 'Definitions'?

The complexity of some terms requires the development of conceptual frameworks as opposed to rigid definitions, to facilitate understanding and accurate measurement.

- **Personal recovery** — better understood using frameworks such as CHIME rather than a strict definition.

- **Resilience** — ongoing debates exist over whether it is a trait, process, or outcome. Attempting to impose a universal definition may not be feasible or helpful.

- **Trauma** — diverse individual experiences mean it is not feasible to accurately and wholly define trauma, and culturally attuned frameworks for identifying and responding to trauma may be more suitable.

- **Early intervention** — a framework is more appropriate, ensuring intervention at the right time and with the right approach.

- **Co-morbidity** — the various ways in which this term can be interpreted are better conceptualised within a framework as opposed to with a single definition.

6.6 Interchangeable Use of Terms

Using similar terms interchangeably can create confusion. Clarifying which term to use will improve communication in mental health research, particularly as some argue that it does not matter which term is used as long as they mean the same thing.

- **Recent onset, early onset, and first episode** — often used interchangeably despite slight differences in meaning.

- **Clinical high risk, ultra-high risk, and prodromal** — frequently conflated terms.

- **Co-occurring disorders, comorbidity, dual diagnosis** — frequently conflated terms.

- **Relapse and recurrence** — used interchangeably despite their different meanings (relapse, occurring within the same episode; recurrence, occurring after recovery). Interestingly, evidence suggests that the demarcation between relapse and recurrence may not be relevant, although both terms are currently used.

6.7 Interdependence of Terms

The inter-dependence of many of the terms and definitions examined within this project, and the fact that this inter-dependence is ignored, is an ongoing issue. Terms are seen in isolation from other terms. For example, symptom intensity, functional level, adherence to interventions, remission rates, recovery, and others, interact with one another. Whether a person is considered to be 'in remission' may relate to their adherence to an intervention; however, adherence is not considered within any definition of remission.

A nuanced approach towards developing consensus definitions is necessary to enable the interplay between each of these terms to be considered in an integrated way, as opposed to being an independent and separate process in which consensus definitions are developed individually for each term.

6.8 Semantics

Some of the language used in mental health research creates confusion. For example, the so-called first episode of psychosis can occur at any time during the period from onset up to five years, rather than referring to the first actual episode of the condition. This unsurprisingly causes confusion for many, including those with lived experience and their families, who understand their first episode to be their initial encounter with mental health challenges, regardless of diagnosis or treatment.

Similarly, the term substance-induced implies causality, yet it is often too simplistic to assume that a condition is directly caused by a substance; indeed, the substance use may serve as a coping mechanism for another condition or may co-occur due to shared risk factors. In practice, it is difficult to distinguish between a drug-induced versus a primary disorder.

Certain terms have also been identified as problematic for other semantic reasons:

- **First episode** can inadvertently suggest the inevitability of future episodes, causing unnecessary anxiety for patients and families.

- **Comorbidity** contains the word morbid, a word with obvious negative connotations.

- **Treatment-resistant** often implies that it is the person who is resistant to treatment, rather than that the condition does not respond to the intervention.

While implementing changes in terminology can be challenging it is possible, and terminology changes can drive broader societal and legal shifts. A notable example is the shift from using the term 'committed suicide' (with the connotations of criminal activity) to using the term 'died by suicide' (viewed as destigmatising and more sensitive), which gained broader acceptance following the decriminalisation of suicide in countries such as the UK (1961). This change reflects the efforts made to reduce stigma and acknowledge suicide as a public health issue rather than a criminal act. Similarly, the shift from compliance to adherence represents a move away from traditional paternalistic and unequal approaches, towards a more collaborative and person-centred model.

6.9 Under-examination of Functioning and Consideration of Functional Outcomes and Functional Impairments

Functioning and considering functional outcomes and functional impairments is significantly underexamined in mental health research. Typically, symptom occurrence or reduction is prioritised as the primary outcome, and hence takes primacy within many definitions, while functioning, seen as a secondary outcome, is rarely included as a part of the definition at all. This is despite functioning's central role in well-being.

Nevertheless, the landscape is shifting and recognition of the importance of functional outcomes in research is increasing. However, this is rarely translated into inclusion within definitions. Further, there is still no clear and accepted framework defining what functioning means within a mental health research context, including which domains are relevant and how functioning itself is conceptualised. This lack of clarity contributes to the variation observed across studies, and different researchers continue to emphasise different aspects of functioning (e.g., social, occupational, or daily living).

6.10 Stakeholder Representation

A key element that has emerged throughout our examination of the literature, and our interviews, surveys, and workshops across this project, relates to the differential influence and power base of stakeholders. While it is clear that there are multiple groups central to creating and agreeing the definitions and operationalisations for the various terms, some groups are consulted much more frequently than others; and groups with less power in the system (such as those with lived experience, or those from low-resource settings or countries) are not provided with the resources, time, or infrastructure which might allow them to contribute fully and meaningfully.

A clear view that has emerged from within this work is that there are a wide range of stakeholders that need to be considered and involved when developing consensus definitions and guidelines. These include individuals with lived experiences of mental health conditions, caregivers and other family members, policy makers, researchers, healthcare providers, and interdisciplinary experts (including perspectives from psychiatry, psychology, sociology, and anthropology).

Although some consensus statements and treatment guidelines have been developed by multi-stakeholder groups, these are rare. Indeed, many definitional statements or guidelines are developed by single-discipline groups, often from within one WHO Region, and sometimes solely by psychiatrists from one area within one country [6,25]. Even on the rare occasions when multi-stakeholder groups are convened to develop such work, these usually comprise HIC stakeholders, often because existing structures make it easier to gather consensus data from a more limited geographical area.

Participants in this project, in line with much published work, argued that definitions and diagnostic tools need to be understandable by, accessible to, and co-developed by all stakeholders — researchers, practitioners, people with lived experience of mental health challenges and their families/caregivers, and the general public.

> Some definitions exist because they are easier to measure. But is that the right way to define them? Who benefits from those definitions: patients, or the system?" [11]
> *– Mental health expert, interview*

11 The quotes highlighted throughout the document are derived from our interviews and consultations.

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7.

Overview of the Definitional Landscape Priority Terms

Priority mental health terms	Condition	Organised consensus efforts [12]	Priority for definitional consensus	Feasibility of developing global consensus
Adherence	Across conditions	No	High	Low Conceptually well understood, but operational definitions vary widely, especially in psychological interventions where adherence is not well-defined. Feasibility is low because, whereas consensus on core principles and thresholds can be achieved, agreement on specific measurement criteria across interventions is challenging, as different measures have their own advantages and disadvantages; and their use can differ based on the context and resources.
First Episode	Psychosis	No	High	High Although there are various definitions, the term is not debated based on ideological or philosophical differences across stakeholders. The need for clarity is established; and because the term is primarily used in only one disorder (psychosis), the complexity in developing consensus is reduced. The term is used in depression, but there is less variability over its use and few issues have arisen over its definition. The term is not widely used for anxiety and hence is not included in the charting here.
	Depression	No		
Functioning, functional outcome/ impairment	Across conditions	No	High	High for 'domains of functioning' Various functioning domains (e.g. social, self-care, occupational, family) are subdivided to create functional outcomes. It is possible to develop consensus both on which are the higher priority domains for use in mental health research, and on their overall definitions. Low for specific outcomes Because the precise outcomes in different domains will vary across cultures, it will be difficult to attain universal agreement on all functional outcomes.

12 Organised consensus efforts refer to an academic publication that proposed an operational or pragmatic consensus definition of the term using consensus-building methods such as the Delphi.

Priority mental health terms	Condition	Organised consensus efforts	Priority for definitional consensus	Feasibility of developing global consensus
Recovery	Psychosis	Yes (for symptom domain)	High	Low There is broad agreement on the distinction between clinical and personal recovery; however, there is no standardised measure of functional recovery. Feasibility is low; while defining symptomatic recovery is achievable, defining functional and personal recovery remains complex due to cultural and subjective factors.
	Depression	Yes (for symptom domain)		
	Anxiety	No		
Relapse	Psychosis	Yes	High	High The concept is widely used but operational definitions are inconsistent (thresholds, measurement tools, proxy indicators like hospitalisation). Feasibility is high; existing efforts to define relapse can be refined to improve consistency in research applications.
	Depression	Yes		
	Anxiety	Yes		
Remission	Psychosis	Yes	High	High There is broad agreement that remission refers to symptom reduction, but variability exists in timeframes, cut-offs, and whether functional remission should be included. Feasibility is high; significant work has already been conducted on symptom remission across conditions — further refinements can align definitions. And we conclude (above) that it is feasible to develop consensus on functioning.
	Depression	Yes		
	Anxiety	Yes		

Priority mental health terms	Condition	Organised consensus efforts	Priority for definitional consensus	Feasibility of developing global consensus
Treatment Resistance	Psychosis	Yes	High	Low Existing consensus efforts define treatment resistance across conditions including depression and psychosis, but discrepancies exist in adherence measurement, treatment duration, and the role of psychological interventions. There is an established need to develop a consensus definition. Feasibility is low: while a universal definition is possible, real-world application is complicated by regulatory and clinical policy limitations, and the fact that the term is disliked by many PWLE[13] and LEEs.
	Depression	Yes		
	Anxiety	Yes		
Comorbidity	Across conditions	No	Low	Low The general definition (coexistence of conditions) is agreed, but operationalisation varies depending on whether conditions are truly independent, interrelated, or hierarchical. Further consensus building is not recommended; our landscaping does not suggest that the existing definitional use impedes progress in mental health research.
Drug-induced	Psychosis	Yes (DSM/ICD)	Low	Low The term is already standardised in DSM and ICD classifications. Critique of DSM/ICD classifications suggests that further consensus efforts without changes to the diagnostic classification are unnecessary.
	Depression	Yes (DSM/ICD)		
	Anxiety	Yes (DSM/ICD)		
Early Intervention	Psychosis	No	Low	High There is limited disagreement over the terminology used. Confusion arises due to overlapping use of the terms prevention and early-life interventions. However, further consensus building is not recommended; our landscaping does not suggest that the existing definitional use impedes progress in mental health research.
	Depression	No		
	Anxiety	No		

13 Person with Lived Experience. For the full list of abbreviations, refer to section 1, page 3.

Priority mental health terms	Condition	Organised consensus efforts	Priority for definitional consensus	Feasibility of developing global consensus
Mechanism	Across conditions	No	Low	Low The term is highly discipline-specific, with varying interpretations in neuroscience, psychology, and psychiatry. Feasibility is low because forcing a universal definition may not be practical given its different uses across research domains.
Prodrome	Psychosis	Yes (UHR/CHR)	Low	High There is broad agreement on the concept and its meaning; further consensus building is not recommended as the term is shifting toward 'clinical high risk'. Our landscaping does not suggest that the existing definitional use impedes progress in mental health research.
	Depression	No		
	Anxiety	No		
Resilience	Across conditions	Yes	Low	Low Definitions vary significantly, with resilience described as a trait, process, or outcome. Given its multidimensional nature, a strict definition may not be feasible or useful.
Trauma & Trauma-informed	Across conditions	Yes	Low	Low The term and its scope are highly contested. The landscape of human experience is vast and everchanging, and as such a consensus definition of trauma is currently unfeasible.
Trauma-informed Care	Across conditions	Yes	High	High The principles of trauma-informed care (though they differ) are well laid out and lend themselves well to a consensus effort.

8.

Strengths and Limitations of the Project

Strengths and Limitations of the Project

8.1 Strengths

8.1.1 Wide Scan of the Research Literature and Guidelines

The team reviewed the research literature and national and international guidelines for each of the 15 selected terms to develop an in-depth understanding of the definitional landscape. The search protocol and search terms for the review were reviewed and subsequently agreed by our MHRC and MHLE advisory groups and by Wellcome. We focused on more recently published literature but placed no restrictions on viewing historic research, so that the evolution of each term could be adequately understood.

In all, more than 7,500 papers were reviewed (including more than 950 in depth).

8.1.2 Extensive and Diverse Consultation

Our process involved extensive consultation, incorporating the perspectives of academics, practitioners, and lived experience experts, and comments and advice from key representatives at Wellcome (see section 11: Acknowledgements). The figures below reflect the total number of participants in each process; it is important to note that several individuals participated across advisory groups, interviews, and workshops, hence there is some overlap.

- We utilised two expert advisory groups. One comprised 7 senior mental health academics and practitioners including those with experience in leading multilateral mental health organisations, and the other (via our collaboration with the GMHPN) comprised 14 LEEs.
- We conducted individual interviews with 25 people: 12 research and clinical experts with extensive experience, and 13 LEEs within the network of GMHPN.
- We gathered views from 140–322 interdisciplinary stakeholders via the on-line survey.
- We held 7 workshops with 67 individuals with professional and/or lived experience expertise.

We also ensured that there was considerable variation with respect to participants and key dimensions, including:

- **Regional variation**—all WHO regions were involved.
- **Gender split**—the gender split was 34% women, 64% men, 2% non-binary.
- **Disciplinary split**—our consultations involved individuals from many professional disciplines in a range of roles.
- **Lived Experience Experts (LEE)**—28%[14] of all participants declared themselves LEEs.

8.1.3 Other Perspectives

We were primarily tasked with exploring the impact on research in general; however, we have purposefully incorporated perspectives from many historically extremely under-researched groups. These include individuals from indigenous communities, underrepresented WHO regions, especially the Eastern Mediterranean and the Western Pacific Regions, and from a diverse range of researchers, clinicians, and people with LE from each of the WHO regions. These efforts have ensured that perspectives from marginalised and underrepresented groups have been meaningfully explored.

14 This is an under-estimate: some participants who had lived experience of mental health difficulties were also professionals and assigned themselves to a discipline instead.

8.1.4 Focus on Lived Experience Engagement

We placed a significant emphasis on incorporating lived experience perspectives, recognising their vital role in shaping both research and practice. This was implemented in a variety of ways: through our partnership with the GMHPN and their network, which constituted our MHLE advisory group; through our close collaboration with the Wellcome funder team's LE representatives, ensuring that LEE voices were central to our work; and through ensuring that LE perspectives were centrally represented in our consultation workshops. These perspectives were reflected throughout the project and are integral to our final report and recommendations.

8.2 Limitations

8.2.1 Research Scope

While our review process covered a wide array of literature, given the 12-month timeframe, we were unable to conduct 15 new systematic reviews. Although the search protocol was thoroughly reviewed and refined, the scope of the search was not exhaustive. As a result, some relevant studies discussing definitions may have been overlooked.

8.2.2 Consultation Limitations

Despite extensive consultations, the samples used in interviews, surveys, and workshops were based on convenience sampling,[15] which introduces potential bias and limits representativeness. While we sought diversity in input, it is important to acknowledge the constraints inherent in the convenience sampling process.

8.2.3 Exclusion of Diagnostic Terminology Issues

Our initial brief focused on the definitional issues related to 15 key terms but excluded discussions on diagnostic terminology, which could provide valuable context. As a result, we did not address the definitional challenges tied to current diagnostic categories within the mental health field.

8.2.4 Balancing Research and Real-World Contexts

Throughout the project, while we focused on the use of the 15 selected terms within research, we also faced the challenge of addressing their application in clinical settings and in broader societal discourse. Feedback from LEEs frequently touched on how these terms are used outside of the research context, and how they may be problematic for individuals with lived experience due to the treatment they experience within professional mental health settings. Striking a balance between academic precision and the practical, lived reality of these terms was complex, particularly as cultural variations and the perspectives of marginalised groups introduced further intricacies.

We have attempted to investigate and relay some of those concerns and issues whist at the same time being mindful of our brief: to develop greater clarity in the research and other related communities, and to develop greater cultural relevance, validity, and global applicability.

15 Convenience sampling is a type of non-probability sampling which involves drawing the sample from the easiest-to-access populations; in this case, via personal contact with key individuals in the global mental health field, or via individual invitation to key researchers or practitioners from indigenous communities and underrepresented WHO regions such as the EMR and the WPR.

9.

Definitional Landscape

This section contains 14[16] summaries of the work undertaken for each of the examined terms. First, we present the terms for which we recommend further consensus development. These are (in alphabetical order): Adherence/Compliance, First Episode, Recovery, Relapse, Remission, and Treatment Resistance.

Next, we present those terms for which we do not recommend prioritising further consensus development at this stage, although there are specific areas within some of these terms where we recommend work should be undertaken. These terms are (in alphabetical order): Comorbidity, Drug-Induced Conditions, Early Intervention, Mechanism, Prodrome, Resilience, Trauma & Trauma-Informed.
The examination of each of the terms follows the same structure, as detailed below:

- A brief introductory paragraph on the meaning of the term, the main issues to be addressed, and a contextualisation of why consensus around a particular term is important.
- A table indicating the number of academic published papers reviewed, with some additional information (year, region). These primarily comprised reviews but also included some individual trials and opinion pieces, as per our search strategy.
- A description of the consensus landscape with respect to the three conditions of interest (psychosis, depression, anxiety) if appropriate for that term.
- Areas of agreement and tensions in the field.
- Conclusions regarding the requirement for further consensus, priority status, and associated barriers.

16 14 as opposed to 15; we have combined two of the original terms (compliance and adherence) into a single term.

Strengths and Limitations of the Project

Terms for which we Recommend Further Consensus Development

9.1 Adherence and Compliance

Compliance and adherence are terms used to describe the extent to which a person with a health condition follows an agreed intervention or treatment plan, such as alterations in lifestyle and diet or taking medication regularly at an agreed dose. However, these terms are frequently criticised owing to the implication that the provider has greater power than the service user, and our experts expressed mixed views on the value of the terms both in research and practice.

Table 9.1 Characteristics of the papers reviewed [17]

Publication Year	No. papers	Region	No. papers
2015-2025	17 (63.0%)	Americas	13 (48.1%)
2004-2014	7 (25.9%)	Europe	10 (37.0%)
1994-2003	1 (3.7%)	Western Pacific	3 (11.1%)
Before 1994	2 (7.4%)	Africa	0 (0.0%)
		Southeast Asia	0 (0.0%)
		Eastern Mediterranean	1 (3.7%)
Totals	**27**		**27**

Consensus Landscape

There is broad agreement on the definition of adherence and compliance; however, there are significant variations in how they are operationalised. This is the case across research and practice within psychosis, depression, and anxiety, and as such, the review below is not condition specific.

An early definition of compliance described the extent to which a patient's behaviour aligned with medical or health advice such as taking medications, adhering to diets, or making lifestyle changes [1]. However, this foundational definition was later criticised for its paternalistic nature [1]. In 2003, the WHO introduced the term 'adherence' to describe the same concept, but with an emphasis on the agreement between patient and provider, defining it as: *"the extent to which a person's behaviour—taking medication, following a diet, and/or executing lifestyle changes—corresponds with agreed recommendations from a healthcare provider"* [1]. In 2005, a report from the NCCSDO[18] [2] critiqued the term compliance and its connotations of patient passivity and lack of agency, highlighting its diminishing usage in favour of alternative terms. They recommended using adherence as a preferred term of choice to describe patients' medicine-taking behaviour, asserting that this term respected the patient's autonomy. As a result, compliance is less commonly used in research in favour of adherence, although the terms may still be used interchangeably [3,4].

More recently, there has been a suggestion to replace both adherence and compliance with concordance, which implies a holistic approach to patient–provider interactions [5-7]. Initially defined as a collaborative decision, concordance evolved into a

17 Table 9.1 indicates the number of academic papers reviewed on adherence/compliance and their characteristics. Region refers to either the region(s) where the study was conducted or the regional affiliation of the first author.
18 National Co-ordinating Centre for Service Delivery and Organisation. For the full list of abbreviations, refer to section 1, page 3.

broader concept encompassing patient communication and support. However, while collaboration may be preferred in some cultures, others may prefer a more prescriptive approach. Further, the degree of concordance appears to examine the extent to which the agreed plan is collaborative, but this does not demonstrate the extent to which the plan is being followed, which is the essence of both 'compliance' and 'adherence'.

Although there is general acceptance of this broad definition: 'the extent to which behaviour corresponds to agreed recommendations', there is no universal gold standard to measure and operationalise adherence. Reviews highlight several such definitions of either adherence or non-adherence within the domain of medication [8–10].

a) Percentage of medication taken (varying cut-offs)
b) Missed doses in a set period of days (varying cut-offs)
c) Self-reporting of medication not taken
d) Ceasing medication without discussion with the service provider
e) Missing medication (at least some of the time)
f) Not collecting medication
g) Not filling prescription.

The lack of consensus on the operationalisation of adherence to medication is further complicated by the varied measures used. Self-reporting is common but may be influenced by a variety of factors; pill counts are inexpensive but time-consuming and inappropriate for most clinical settings; electronic monitoring devices are expensive and not always feasible; therapeutic drug bloodstream monitoring can confirm ingestion but is intrusive and resource-intensive; and pharmacy records can be highly unreliable [11]. Since studies are situated within the constraints of resources, feasibility, and access, it remains difficult to determine which measure is more suited. Therefore, a minimum of one standardised metric to measure non-adherence in research may be more suitable.

The understanding of adherence or compliance in psychological interventions is limited. It is often described as the completion or non-completion, or the initiation or non-initiation, of the psychological treatment. However, this does not portray the extent to which the person engaged with the intervention; such definitions are problematic in research since engagement is as important as attendance [12,13].

The measurement of adherence in psychological interventions is also less explored. A recent review identified two operationalisations: (a) adherence as completing the entire intervention and (b) adherence as the proportion of completed sessions relative to the total available sessions [14]. These are more useful than defining adherence as simply starting an intervention; however, they are still inadequate since a participant can attend every session of an intervention but not actively participate nor implement strategies in daily life. This therefore makes session attendance an unreliable measure of adherence. Other measures include completing questionnaires or assessments [15], completing homework [16], or self-reporting. Similarly, self-reported data may be inaccurate, and while objective metrics such as sessions completed or login frequency may be used, these may not capture the true level of engagement [17]. Further difficulties arise when low-cost task-sharing interventions are examined. Several socio-cultural factors may have an impact, such as offering sessions outside of the home to people with limited mobility or enacting unrealistic treatment recommendations. These highlight a need to develop objective criteria for the measurement of adherence in non-pharmacological interventions that can be applied in different settings and contexts.

Areas of Agreement and Tensions in the Field

Agreements

- There is broad agreement on the definition and concept of adherence.

- For pharmacological interventions, studies generally define adherence as taking prescribed medication as instructed at least 75-80% of the time [8–10].

Tensions

- Lack of standardised operationalisation of adherence definitions

There is no universally accepted operational definition or measure of adherence, leading to inconsistencies across studies; pooled adherence rates may be inaccurate and other terms which rely on adherence for their own definitions (e.g., remission, treatment resistant) subsequently become less reliable.

- Pharmacological treatments

Each existing measure has its own advantages and limitations. No single gold standard has been established; lack of consistency poses challenges for comparing studies and improving treatments.

- Non-Pharmacological interventions

Measuring adherence in psychotherapy and other behavioural interventions is complex. Session attendance alone does not indicate adherence, and alternative measures (therapist or client self-reports, independent observational ratings) may be influenced by socioeconomic or other barriers.

- Western focused

Most adherence measures have been developed in HICs within well-established healthcare systems. These tools often lack cultural and contextual applicability in LMICs, making them less reliable in diverse healthcare settings [18].

- Inadequate attention to factors beyond individual control

Significant debate exists around the reasons for non-adherence, and the extent to which these should alter conceptualisation. Reasons for non-adherence can be complex: experts highlighted that people may consciously not adhere for many reasons, such as lack of affordability or trust.

However, even in the absence of such barriers, behaviour change literature indicates that many people do not follow through on their intentions [19,20].

- Opposing stakeholder views

Adherence and compliance evoked starkly opposing views. Many among both LE experts and MH experts viewed the concept as perpetuating stigma towards people who do not adhere, particularly as non-adherence may be a direct result of the mental health condition. Others stated that the focus should be on improving the treatments offered, not redefining adherence. On the contrary, many MH experts supported the view that clear operationalisation of adherence would improve research and treatment outcomes.

Conclusions

Is further consensus needed?

Yes, we recommend further consensus building for the definition of adherence.

Our review and consultations point to a great deal of variability in its operationalisation in research, and concerns from people with lived experience on how adherence is defined. Further efforts must:

- Include LEEs in any definitional or consensus work.
- Define adherence through a sociocultural lens.
- Develop clearer operationalisation for medication adherence.
- Clearly define adherence in the context of psychological treatments.

What is the priority?

High priority.

Adherence is relevant to all interventions and treatments in mental health research, and as such there are ramifications for understanding outcomes in mental health interventions. Further, a lack of consensus affects the definition of related terms such as treatment resistance.

What are the key barriers and tensions to resolve before consensus is achieved?

Socioeconomic factors, health literacy, and cultural contexts all shape how adherence is measured and practiced, causing challenges in establishing a universally accepted definition. In psychological interventions, defining adherence must consider diverse opinions, the dynamic nature of therapies and patient–client relationships, and individuals' unique engagement milestones. Finally, competing priorities among many healthcare providers (with a focus on whether or not treatment recommendations were followed) and many patient advocates (with a focus on the reasons why a PWLE may not follow treatment recommendations) may be difficult to reconcile.

> Why do we only talk about whether a person is following the treatment and not whether the treatment is following the person?"
> *– Lived experience expert, interview*

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9.2 First Episode

Contrary to expectations, **first episode** may not refer solely to the first time someone has an 'episode'. Instead, it refers to the initial onset or to a recent onset [1] of a mental health condition, or to a person's first contact with clinical services [2]. People with lived experience generally understood the term to mean the first time they experienced a specific mental health condition; however, our interviews and consultations revealed numerous variations. Concerns were flagged over the different meanings, the measurement and temporality of the first episode, the exclusion of issues other than psychiatric symptoms in the identification of a first episode, and the retrospective nature of any classification. Participants also suggested that a clearer definition would aid in early intervention.

The review below focuses on psychosis. This is because there have been no documented consensus efforts on defining first episode in depression and based on our review, when used in research, first episodes in depression are understood using the diagnostic criteria for major depressive disorder, without explicitly stating how they have been operationalised [3-4]. The term is rarely applied in anxiety.

Table 9.2 Characteristics of the papers reviewed [19]

Publication Year	No. papers	Region	No. papers	Condition	No. papers
2015-2025	35 (61.4%)	Americas	22 (38.6%)	Depression	5 (8.8%)
2004-2014	11 (19.3%)	Europe	22 (38.6%)	Psychosis	52 (91.2%)
1994-2003	6 (10.5%)	Western Pacific	8 (14.0%)		
Before 1994	5 (8.8%)	Africa	3 (5.3%)		
		Southeast Asia	1 (1.8%)		
		Eastern Mediterranean	1 (1.8%)		
Totals	**57**		**57**		**57**

Consensus Landscape

Psychosis

We did not identify a consensus definition for first episode in psychosis. Although it is commonly used to describe people's early experience of the condition as defined in DSM or ICD[20] (e.g. 2–5 years after onset), this is not universally accepted.

19 Table 9.2 indicates the number of published academic papers reviewed on first episode and their characteristics. Region of publication refers to either the region(s) where the study was conducted or the affiliation of the first author. Some papers were attributed to more than one region.
20 For the full list of abbreviations, refer to section 1, page 3.

Breitborde and colleagues suggest three categories to define first-episode psychosis (FEP):

- first treatment contact – an individual who presents with psychosis in a clinical setting for the first time
- duration of antipsychotic medication use – an individual who has not received regular antipsychotic treatment for more than 6* weeks prior to contact with the index service (*variable)
- duration of untreated psychosis (DUP) – a prespecified duration (commonly 2–5 years) during which a person experiences psychotic symptoms [5].

Of these, the DUP definitions were found to be most variable. Interestingly, the definitions mentioned differ from those commonly used by individuals with lived experience and their caregivers, which usually relate to the first manifestation of a condition, often occurring long before any service contact or treatment.

Definitions can vary based on multiple parameters [6]:

- Onset – defined variably as: onset of positive symptoms; first appearance of any psychotic symptoms; onset of hallucinations, and/or delusions, and/or disorganised thinking and/or behaviours; onset of 'frank' psychosis.

- Treatment – period between onset and treatment, where treatment is variably defined as: presentation to a mental health service; receipt of treatment; initiation of appropriate clinical treatment; initiation of successful psychiatric treatment.

Definitions around prior exposure to treatment also vary. Some trials entirely exclude individuals who have had any prior treatment, to include only drug-naïve patients [6,7]. Others allow those who have had limited treatment within the weeks or months before the start of the trial, or a maximum cumulative total number of weeks over their lifetime [8,9].

We identified a broad agreement that people who access services for first-episode psychosis, or for inclusion in trials, must have a maximum age of 40-45 years [10–12]; this may reflect the consensus that very late-onset schizophrenia-like psychosis reflects a distinct condition which is possibly neurodegenerative.

Depression and Anxiety

Studies which use the term 'first episode' when discussing depression use the diagnostic criteria for major depressive disorders, and recent reviews do not highlight any issues pertaining to this definition that hinder comparability across studies [3-4, 13-15]. In our review we did not find similar issues (related to definition, and to the lack of consistency around onset and time periods) in understanding what a 'first episode' of depression was, as emerged when we examined this term in relation to psychosis.

The concept of a first episode of anxiety is not well utilised, and hence this is not included in this definitional landscape.

Areas of Agreement and Tensions in the Field

Agreements

- Lived experience and mental health experts highlight the importance of the term in the development of early interventions.
- Our research showed that most definitions of first-episode psychosis set an upper limit of 5 years from onset.

Tensions

- First treatment contact as an inadequate proxy

The definition of first episode often applies to the initial presentation, i.e. the first presentation in a clinical setting or the first professional recognition of behaviour indicative of psychosis. Our LE and MH experts strongly argued that this definition is problematic in contexts where services are not available or where individuals may not seek clinical care due to stigma, accessibility issues, or cultural differences.

All definitions based on first access to services or the receipt of first medication are predicated on such services existing and being accessible.

- Misleading language

The term does not necessarily equate to the literal first episode, which can cause confusion. Lived experience and other experts argue that the term first episode is too vague; it is unclear whether it relates to the first indication of one symptom, the first appearance of a number of symptoms, the first onset of a diagnosable disorder, or when a person first seeks treatment.

Our experts also highlighted that first episode is not the most helpful term; there was some suggestion that using terminology such as recent onset should be considered instead, given that this was often what was being measured.

- DUP

The time between onset and treatment used to define DUP varies from 2–5 years; there is no consensus on cut-offs for shorter or longer DUP. This is crucial, since a long or short DUP can affect patient outcomes [16]. Additionally, there is some variation in the definition of treatment; some definitions include the period between onset and initiation of treatment, whereas others include the period between onset and successful or adequate treatment—these are considerably different in nature, and these differences impact on both the standardisation of research outcomes and clinical interventions. Further, definitions necessitating so-called successful treatments can only be applied retrospectively, which while useful for research is not feasible in practice or when requiring early intervention.

- Duration of antipsychotic use

The term duration of antipsychotic use provides a clear, objective criterion for clinicians and researchers, but it is considered an unsatisfactory proxy for several reasons [5,7]. Firstly, there is considerable variation in the accepted medicated period during research trials, ranging from ≤3 days to 6 months, and in some cases no medication is deemed acceptable at all, i.e. participants must be drug naïve. Secondly, as highlighted by both MH and LE experts, antipsychotic usage relies upon a professional recognising that an individual requires medication, and that the medication is available, accessible, and affordable.

- Age range

There is variation in the upper and lower age limits of the people considered eligible for inclusion in studies or entitled to access services for first-episode psychosis[21]. While many studies and services welcome individuals aged up to 40 years, some are more flexible; similarly, some services and studies accept people as young as 13 years of age, although others stipulate a minimum age of 18 years.

- Pessimism and exclusion of functioning

Debates within our consultations included whether the term first episode carries an implication that there will be further episodes, hence introducing the idea that psychosis is a chronic and recurring condition. However, others argued that it is a simple, factual term which does not imply anything about possible future episodes.

Many LEEs also asserted that changes in functioning can signal the early signs of a condition, yet this aspect is frequently overlooked in the understanding of a first episode.

Conclusions

Is further consensus needed?

Yes. We recommend further consensus building for the definition of a first episode.

In particular, we propose addressing the following areas of disagreement: variability in duration, over-reliance on contact with treatment services, initiation versus successful treatment completion, and medication usage history. Experts and lived experience groups also consider the term too vague and potentially misleading, with some agreement that a term such as recent onset might be more suitable. A clearer, standardised definition would improve research comparability, clinical care, and early intervention strategies.

What is the priority?

High priority.

The identification of the first episode of a condition is closely interconnected with early intervention, and consequently with more or less successful patient outcomes.

First episode (or recent onset) was also deemed a non-labelling and non-judgemental term, although further clarity would benefit both those with lived experience and their caregivers, researchers, and clinicians.

What are the key barriers and tensions to resolve before consensus is achieved?

Our experts highlighted that wider debate is needed regarding the qualification of a psychotic episode, as the definition of early-stage psychosis remains complex and lacks clear agreement. Different perspectives shape how it is understood; our literature review showed that in North America, psychosis is often primarily associated with schizophrenia, while in Europe, the definition tends to have broader scope.

21 Although there is often variation around inclusion / exclusion criteria between services and especially between studies, with respect to a number of areas, including age, these variations in upper and lower age ranges are especially marked in services for / studies on First Episode, although also see the later Landscape on Early Intervention.

Another key barrier is the applicability of the definition in contexts where treatment options are limited, where a definition relying on presentation, hospitalisation, or treatment may be difficult or impossible to implement.

Finally, experts highlighted that in practice it can be difficult to determine whether someone presenting with a psychotic state has experienced this before; such information is often only available via family or health records, which may not always be accessible. Information provided by the patient or their caregivers may also be prone to recall bias, as it is frequently assessed retrospectively.

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9.3 Functioning, Functional outcomes/impairment

The concept of **functioning** in mental health refers to the ability of individuals with mental health problems to perform daily activities and maintain roles in various life domains, including work, social interactions, and independent living. Measuring **functional outcomes or impairments** is seen as important in mental health as a counterbalance to the dominance of symptom reduction as a primary outcome. Despite its importance, there are problems in how the concepts are operationalised and measured, which can hinder effective treatment and recovery strategies. The terms were recommended for this landscaping by lived experience and mental health experts we surveyed and consulted with, due to their importance as an outcome in any condition or intervention.

Table 9.3 Characteristics of the papers reviewed [22]

Publication Year	No. papers	Region	No. papers
2015-2025	35 (83.3%)	Americas	19 (44.2%)
2004-2014	3 (7.1%)	Europe	17 (39.5%)
1994-2003	3 (7.1%)	Western Pacific	6 (14.0%)
Before 1994	1 (2.4%)	Africa	0 (0.0%)
		Southeast Asia	1 (2.3%)
		Eastern Mediterranean	0 (0.0%)
Totals	**42**		**43**

Consensus Landscape

There is general agreement that **functioning** assesses a person's behaviour; the way they act and interact in different areas of their lives. This includes work or education [1], maintaining relationships and friendships [2], societal interactions, independent living, cognitive functioning, and physical functioning [3]. **Functional outcomes or impairment** relate to the extent that someone is able to demonstrate their level of functioning (or their level of remaining impairment) within these domains, following intervention for a mental health condition. The terms are sometimes used interchangeably with functional recovery, which has operationalisation variations regarding the ability to independently function in everyday life [2,4].

There is a globally internationally agreed classification system: the International Classification of Functioning, Disability, and Health (abbreviated to ICF) [3], which has considerable potential utility as a framework which both separately assesses and also links together symptoms (body functions), functioning (activities and participation) and environmental factors (the physical, social and attitudinal environment in which people live and conduct their lives). The creation of the ICF then led to the development of the WHO Disability Assessment Schedule [WHODAS, 5]. In 2001, ICF was officially endorsed by all 191 WHO Member States in the Fifty-fourth World Health Assembly, as the international standard to describe and measure health and disability. ICF has the potential to be used very widely within mental health research, and there have been efforts to do so [6,7]. One of the issues that has arisen is its comprehensiveness, covering as it does all aspects health and health-related states: it can seem extremely unwieldy. Attempts have been made to create sub-sets related to specific MH conditions (e.g. for psychosis [8], for depression [9] or for 'mental disorders' more generally [10]) but these have not so far been widely accepted.

22 Table 9.3 indicates the number of published academic papers reviewed on functional outcomes/impairment and their characteristics. Region of publication refers to either the region(s) where the study was conducted or the affiliation of the first author. Some papers were attributed to more than one region.

For example, the 2013 sub-set [10] examining activities and participation according to the ICF has been cited only 11 times, and even the 2004 subset for depression [9], developed through a comprehensive consensus method integrating evidence and expert opinion based on the ICF framework and classification, has been cited only 176 times in the past 21 years. The result is that, when functioning is examined within mental health research, it is looked at very inconsistently across different studies.

One of the key inconsistencies that emerges is the different areas which are examined across studies [11,12]. This is the case across research and practice within psychosis, depression, and anxiety, and as such, the issues raised below are not condition specific.

Functioning is defined in various ways—subjective perceptions of quality of life, return to normalcy [13], or everyday living skills [14]. Definitions of social functioning include those that address social participation, social skills, social adjustment, or social competence [15]. In a recent review on functioning in schizophrenia, 32 measures of social functioning were identified [16], yet not all of them considered important domains such as sexual functioning or social media use [17]. A separate review highlighted 36 measures, of which the most commonly used, GAF,[23] was identified as among the least sensitive to change in function, over time or treatment response [18].

Functioning includes mental, daily, social, and occupational functioning. The first clear definition of psychosocial functioning was described as "*the ability of an individual to form functional relationships with others and society in a mutually satisfying manner and to perform their role on their own to accomplish a healthy life*" [17]. However, the ways in which such a definition is operationalised varies. There is no existing gold standard for psychosocial functioning assessment; 18 commonly used measures exist to assess global functioning, quality of life, occupational functioning, and well-being [19].

23 Global Assessment of Functioning. For the full list of abbreviations, refer to section 1, page 3.

These findings highlight the need to develop consensus on a specific definition and the operationalisation of the concept of functioning, as well as on the optimal functional measures to include in clinical trials [19,20].

Functional impairment refers to the level of impairment that individuals with mental health problems may experience in their ability to perform daily activities and maintain various roles in life, such as work, social interactions, and independent living. Functional impairment can be conceptualised as the real-life consequences of a disorder [21].

Areas of Agreement and Tensions in the Field

Agreements

- There is broad agreement on the range of areas that should be included within the understanding of functioning, functional outcomes, and functional impairment.

- These areas are: Social - relationships with friends, acquaintances, and their wider social circle; Self-care - maintenance of physical health, nutrition, mobility, and the capacity to manage their own affairs; Occupational - studies, work, leisure activities, domestic activities; Family – relationships with members of their own and extended family [3,22].

Tensions

- Inclusion of various other concepts

Adaptive life skills, subjective well-being, and quality of life; all distinct from behavioural functioning.

- Cultural variability

The operationalisation of many areas or domains which constitute functioning will differ depending on context, which makes precise definitions challenging. Our LEEs and MHEs noted that aspects of functioning differ hugely across different cultures, and between high-income to low-income, rural to urban, and other intersecting identities. As such, developing a concise set of functional outcomes risks oversimplification, while a long list could overwhelm researchers and practitioners (as has been the case with the ICF) and still lack sufficient variability.

- Use of various measures and measurers

There is no gold standard measure to assess functioning. There are variations in the cut-offs used to determine functioning on standardised scales. There are several measures for domains such as work or social recovery but limited evidence on whether they actually capture real-world functioning [10].
Descriptions of positive functioning can vary widely; although functioning has moved the focus away from solely symptoms, there remains overlap between functional and symptom-related outcomes. However, neither LE and MH experts expressed major concerns about overlapping terms, since conceptual and methodological overlap is unavoidable.

Different accounts as to levels of functioning may be offered, depending on who is doing the reporting: self-report, clinician report, caregiver report. When different accounts of levels of functioning are provided, there is a tension over which account might be given priority.

Conclusion

Is further consensus needed?

Yes, we recommend further consensus building for the definition of functioning/functional outcomes/ impairment within mental health research generally and within the specific areas of psychosis, depression and anxiety in particular.

There was general agreement from both LE and MH experts that functional outcomes and symptom outcomes are of equal importance and must be recognised as such.

Unlike with other terms examined for this project, we do not recommend further consensus building on the precise operationalisation of measures within these agreed domains. What is considered functional or impaired depends on societal expectations and cultural norms. While most of our experts argued that clearer definitions could strengthen research and intervention strategies by moving beyond symptom reduction, others cautioned that imposing rigid operationalisations could do more harm than good, especially in diverse cultural contexts.There was general agreement across both LLEs and MHEs that a broader framework on functioning (i.e. agreeing domains as outlined above), which is co-produced with individuals with lived experience and caregivers, could offer structure while allowing communities to determine how those functional outcomes may be operationalised in their own settings.

The ICF offers an already internationally agreed framework within which further clarification over the assessment and measurement of functioning could be developed. This could helpfully be based on the developmental work already undertaken within this field (e.g. 6-10)

What is the priority?

High priority.

Functioning is relevant to service users, researchers, and clinicians; it plays a key role in how other terms are defined and understood.

What are the key barriers and tensions to resolve before consensus is achieved?

Considering different cultures and contexts is essential. An agreement needs to be reached amongst researchers and service users regarding how strict or flexible a definition needs to be; our consultations point to the need for a flexible framework, though this may not be universally endorsed.

The overlap between functional and symptom outcomes complicates measurement, as many tools assess both simultaneously. This may be a reason why the existing consensus efforts to develop sub-set of the ICF oriented specifically to mental health, or even more specifically to psychosis, depression or anxiety, have not yet gained significant support.

> I believe defining them is crucial to ensure we don't overlook the importance of function. Clinicians often focus solely on symptoms and may miss functional domains, which don't always improve alongside symptom relief"
> *– Mental health expert, workshop consultation*

> Having a broader definition of functional outcome could aid in having a framework that could be helpful so as to ensure the interventions are not only based on symptoms"
> *– Mental health expert, workshop consultation*

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9.4 Recovery

Research on mental health **recovery** is largely focused on two distinct perspectives: clinical recovery (which includes both symptom remission, and functional recovery - fulfilling societal and cultural roles) and personal recovery (which includes finding personal meaning and satisfaction in life despite ongoing symptoms, developing meaningful life goals and experiencing individual well-being). Recovery is increasingly viewed as a multi-dimensional and subjective concept which includes spiritual, psychosocial, and political domains influenced by language, context, culture and other intersectionality. Many researchers recommend using a combination of clinical and personal perspectives to describe recovery [1–5].

Table 9.4 Characteristics of the papers reviewed [24]

Publication Year	No. papers	Region	No. papers	Condition	No. papers
2015-2025	46 (41.1%)	Americas	50 (44.6%)	Depression	23 (20.5%)
2004-2014	54 (48.2%)	Europe	45 (40.2%)	Psychosis	56 (50.0%)
1994-2003	10 (8.9%)	Western Pacific	9 (8.0%)	Anxiety	2 (1.8%)
Before 1994	2 (1.8%)	Africa	1 (0.9%)	Bipolar	10 (8.9%)
		Southeast Asia	2 (1.8%)	Mental Health	18 (16.1%)
		Eastern Mediter -ranean	0 (0.0%)	Severe Mental Illness	2 (1.8%)
		Multiple	5 (4.5%)	Trans -diagnostic	1 (0.9%)
Totals	**112**		**112**		**112**

24 Table 9.4 indicates the number of academic published papers reviewed on recovery and their characteristics. Region of publication refers to either the region where the study was conducted or the regional affiliation of the first author.

Consensus Landscape

Perspectives on Clinical Recovery

Schizophrenia

Although the RSWG[25] has established a common definition for symptomatic remission (see the landscape on remission), there is no agreement regarding the criteria for acceptable functioning across the psychoses [6]. Liberman and Kopelowicz defined clinical recovery in schizophrenia as *"full symptom remission (most commonly defined using the RSWG criteria of PANSS ≤3 or Scale for the Assessment of Negative Symptoms (SANS) ≤2/ Scale for the Assessment of Positive Symptoms (SAPS) ≤2), full- or part-time work or education, independent living without supervision by informal caregivers, and having friends with whom activities can be shared, all sustained for a period of 2 years"* [7, cited 275 times]. Nevertheless, most studies solely assess symptomatic (not functional) recovery; and even with symptomatic recovery and despite the RSWG criteria, these criteria are not consistently applied. Many studies simply use definitions pertaining to the absence of continuous psychosis or of psychiatric admission [8].

Definitions of functional recovery are also highly variable; there is no standardised definition, as is described in the Landscape on 'functioning'. While many studies use the GAF or Social and Occupational Functioning Assessment Scale (SOFAS) to establish a satisfactory level of functioning, incompatibilities remain. Measures of function are inconsistent—some use hospital admissions, others assess whether a person is living independently or in supported housing.Vocational measures vary from employment history to previous-level work. Social functioning may be defined as having regular social interactions, although standardisation is challenging due to cultural differences. Although standardised functioning scales are available, cut-offs are not clear, defining functioning as simply high or low [6–8].

Lee et al. recently proposed a consensus definition for recovery: a) maintaining age-appropriate socio-occupational functioning, b) absence of PANSS/SANS items, c) no medication, d) Clinical Global Impression Scale-Severity (CGI-S) score ≤1 (normal, not at all ill), and e) GAF or SOFAS ≥71; all sustained for ≥1 year; but this has only been cited 16 times since 2020, implying a lack of uptake [9].

Bipolar

Our review suggests that there is some agreement in research regarding symptomatic recovery: the virtual absence of depressive or manic symptoms for at least eight consecutive weeks [10-12]. Tohen operationalised this as: ≤5 on the Young Mania Rating Scale (YMRS) and ≤8 on the Hamilton Rating Scale for Depression (HAM-D). Another definition involves no longer meeting the DSM criteria for an acute mood episode [12].

Definitions vary widely for functional recovery; criteria include a Functioning Assessment Short Test (FAST) score of <12 or 12–20, or a return to premorbid function levels sustained for at least eight consecutive weeks [13]. LEEs highlight that systemic inequities, stigma and discrimination must be considered, since socioeconomic status, disability, employment opportunities, access to healthcare, and social support (all influenced by stigma and discrimination) impact a person's ability to reach and sustain functional recovery.

25 Remission in Schizophrenia Working Group. For the full list of abbreviations, refer to section 1, page 3.

Depression

There is no consensus on defining clinical recovery in depression; again, there is a greater focus on symptomatic as opposed to functional recovery [14], indeed symptom assessment is utilised in up to 80% of studies [15].

Symptomatic recovery in depression is frequently quoted as an 8-week period of no longer meeting DSM criteria for major depression [16], others include ≥2 months with ≤2 mild MDD [17] or the end of an episode following a remission period of ~6–12 months [18]. In our review, we found 19 unique and highly variable definitions of recovery in adolescent depression; time points range from 6–104 weeks, while cut offs include Hamilton Depression Rating Scale HDRS <9 and HDRS ≤6. Some studies use a sustained low symptom status as a definition criterion, others do not [19]. Little empirical evidence exists to compare criteria, although Judd and colleagues describe minimal benefits of defining recovery as lasting for 8 weeks vs. 4 weeks [20].

While no universal definition of functional recovery in depression prevails, it is often based on pre-specified cut-offs on one or more standardised scales [21].

Anxiety

There is no consensus definition on recovery in anxiety disorders. Definitions include no longer fulfilling the DSM-IV criteria of the index disorder after 3 years [22], 8 consecutive weeks at a psychiatric status rating of ≤2 [23], or self-reporting at recommended cut-offs [24].

Perspectives on Personal Recovery

The most cited definition of personal recovery (>6,130 times) defines it as "*a deeply personal, unique process of changing one´s attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness*" [25]. While there is no single consensus definition of personal recovery, it is acknowledged that personal recovery is inherently subjective. The CHIME conceptual framework [2] links five recovery processes: connectedness; hope and optimism about the future; identity; meaning in life; and empowerment. The framework has been widely adopted [26] and is generally considered applicable across cultures and countries [27], although some have argued that it does not fully capture culture-specific factors such as spirituality, stigma, and collectivism [28]. Adaptations including CHIME-POETIC for bipolar disorder [29] and C-CHIME [30] have also emerged.

Delphi studies involving experts by experience provide insights on key components of personal recovery: attaining a personally acceptable quality of life, feeling better about oneself, becoming empowered, leading a fulfilling life, feeling safe, andbeing recognised as a subject with rights [1,31].

Perspectives on Social Recovery

There is no agreed consensus definition on social recovery. Common definitions include societal culture, a sense of belongingness, social and recovery capital, employment, and citizenship [32]. Social recovery appeared rarely in our review and when it did, it was inconsistently integrated alongside personal recovery.

Reasons for this include a biomedical approach which does not incorporate social recovery, the multi-dimensional nature of social recovery, and the fact that its examination does not lend itself well to randomised controlled trials [33].

Areas of Agreement and Tensions in the Field

Agreements

- Recovery is highly personal and varies across individuals and conditions. *"It is not simply the absence of illness",* a lived experience expert notes, *"but is a continuous non-linear journey rather than a fixed outcome, involving stages like acceptance, rebuilding, and reintegration."*

- There is no gold standard for measuring personal recovery [34]; culturally attuned personal recovery measures are being developed with potential for use in routine clinical practice [2].

Tensions

- Defining functional recovery

Functional recovery is poorly defined. Which functioning dimensions should be assessed, how they should be measured, and the appropriate cut-offs to apply are debatable. Assessing functional recovery against premorbid functioning levels is highly problematic if premorbid functioning was already suboptimal.

- Inconsistent measures

Defining recovery using standardised outcome measures remains context dependent and removes the subjectivity inherent in personal recovery.

Within clinical recovery, varied cut-offs, differing time durations, and sustaining low-symptoms status impede data synthesis efforts necessary for high-quality meta-analyses and the calculation of [35] and distinction between [16] clinical outcomes.

- Consumer-led vs. research- or provider-led definitions

LEEs stated that recovery should be defined and directed by the person themselves, based on their own values, goals, and experiences. They argued that leaving space for personal meaning-making, including accepting ambiguity around what 'being well as a person with a mental illness' looks like, is helpful and important. Researchers and healthcare providers prefer a more objective view, prioritising clear, measurable outcomes to guide clinical decisions and communication with patients and families.

Conclusion

Is further consensus needed?

Yes, we recommend further consensus building for the definition of recovery.

In particular, clarity around the following is necessary: 1) what symptomatic recovery entails; 2) understanding functional recovery from PWLE and caregivers' perspectives; 3) formulation of condition-specific definitions; 4) determination of the essential criteria for recovery while not undermining other perspectives.

The production of recovery definitions and frameworks must be co-produced with those with lived experience, to reflect what they consider meaningful [5,36–39].

What is the priority?

High priority.

Recovery is a commonly used yet complex construct; interpretations across research, clinical practice, and lived experience perspectives vary considerably. Despite the importance of functioning, there is no standardised way to measure functional recovery.

What are the key barriers and tensions to resolve before consensus is achieved?

Recovery means different things to different individuals. Attempts to develop a consensus may lead to the invalidation of individual experiences and result in outdated self-realised definitions; clinicians' and policymakers' reluctance to consider alternative ways of thinking about recovery could be an issue.

The standardised scales used in research to assess different aspects of recovery vary widely, and clarity around cut-offs, symptom duration thresholds, and functional benchmarks would be beneficial, while facilitating flexibility in different populations and cultural contexts. Recovery definitions as used in mental health research have historically been shaped primarily by clinical and research perspectives with limited input from PWLE.

> It is feasible to reach a consensus on the definition of recovery if it involves interactions with and the empowerment of people with lived experience."
> *– Mental health expert, workshop consultation*

> Recovery or remission are important concepts as they lead to improved life quality, better work opportunities, and education, all of which are related to human rights. Empowering those with lived experience is crucial to this process"
> *– Lived experience expert, workshop consultation*

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9.5 Relapse

There is no universal consensus on the definition of **relapse** in anxiety, depression, or psychosis. Relapse is generally recognised as the return or worsening of symptoms after a period of remission, but before recovery. Recurrence, often used in tandem with relapse, is conceptualised as a new episode, post-recovery. There are issues regarding how this concept is operationalised, with variations in diagnostic thresholds, functional impacts, and timeframes [1–3]. Lived experience perspectives highlight that relapse is not solely about symptoms and their return, but a disruption in daily life, relationships, and overall well-being—factors that clinical definitions often overlook. Workshop discussions highlighted relapse is often associated with substance use, limiting its recognition in other mental health conditions.

Table 9.5 Characteristics of the papers reviewed [26]

Publication Year	No. papers	Region	No. papers	Condition	No. papers
2015-2025	36 (57.1%)	Americas	26 (39.4%)	Depression	19 (30.2%)
2004-2014	18 (28.6%)	Europe	35 (53.0%)	Psychosis	30 (47.6%)
1994-2003	8 (12.7%)	Western Pacific	3 (4.5%)	Anxiety	9 (14.3%)
Before 1994	1 (1.6%)	Africa	0 (0.0%)	Mental Health	5 (7.9%)
		Southeast Asia	2 (3.0%)		
		Eastern Mediterran -ean	0 (0.0%)		
Totals	**63**		**66**		**63**

Consensus Landscape

We examined relapse separately for each condition; multiple definitions exist across all conditions.

Psychosis - Schizophrenia

Multifactorial criteria have previously been developed [4], but their application in research has been inconsistent. A recent meta-analysis identified 12 different definitions of relapse, with general hospitalisation being the most common, followed by psychiatric- and schizophrenia-related hospitalisation [3]. However, studies often measured hospitalisation inconsistently, using proxies such as administrative claims, medical chart reviews, and differing criteria for inpatient admission. A recent review of long-term antipsychotic trials identified 54 definitions of relapse, with hospitalisation remaining the most common (43%) [5]. Similar inconsistencies have been reported previously [6].

The measure of hospitalisation is tangible and easy to use; however, our research demonstrates that this fails to capture the reality of relapse. Not everyone who relapses will require hospitalisation; others may not have access to hospital care. In regions with limited mental health infrastructure, hospitalisation-based definitions risk underestimating relapse prevalence and exclude those who experience relapse outside of clinical settings [5].

Three recent consensus efforts have been reported. San et al. used a Delphi methodology to define relapse pragmatically as the re-emergence of psychotic symptoms lasting ≥1 week, causing impaired function, and requiring increased clinical care. They also proposed an operational definition based on changes in PANSS [27], CGI, and GAF scores [7].

26 Table 9.5 indicates the number of academic published papers reviewed on relapse and their characteristics. Region refers to either the region(s) where the study was conducted or the regional affiliation of the first author.
27 Positive and Negative Syndrome Scale. For the full list of abbreviations, refer to section 1, page 3.

The Korean Schizophrenia Society defined relapse in first-episode psychosis, applying criteria such as psychiatric hospitalisation, a ≥25% increase in PANSS score, self-injury, suicidal or homicidal ideation, violence, and symptom exacerbation [8], based on a modified version of [4]. Siafis et al. determined the most sensitive relapse cut-off: an increase of ≥1 point using modified Csernansky criteria or ≥12 in PANSS total score [9].

However, the challenge of balancing sensitivity and specificity in relapse criteria impacts the widespread uptake of these definitions [9].

Psychosis - Bipolar

Relapse is common in bipolar disorder, yet there is no consensus on defining relapse or recurrence; the terms are often used interchangeably, complicating research and clinical practice. The International Society for Bipolar Disorders (ISBD) Task Force defines relapse as a new episode occurring within, and recurrence as a new episode occurring after, 8 weeks of remission [10]. Research definitions vary and include psychiatric admission or new treatment initiation within six months [11], DSM-IV-defined episode recurrence [12], hospitalisation or crisis service referral [13], and re-emergence of full syndrome criteria after remission.

Depression

There is no consensus on defining relapse in depression. The American College of Neuropsychopharmacology (ACNP) Task Force [14] previously proposed a definition as being the reappearance of core depressive symptoms meeting the DSM-IV-TR criteria for a Major Depressive Episode (MDE) for ≥2 weeks, building upon Frank's conceptualisation of relapse [15].

Many studies define relapse as meeting the DSM diagnostic threshold; Zhou et al. found the DSM-based definition was most common, followed by HRSD ≥14 for two weeks, PSR ≥ 5, and LIFE ≥ 3 [16]. Methods varied, using SCID-I, MADRS-S, or PHQ-9 (cut-off range 5–10). Further inconsistencies have been identified in thresholds, time criteria, and proxy indicators [17].

Further complicating the matter, many studies use recurrence instead of relapse while failing to clearly differentiate between the two, leading to a paucity of data on relapse in depression [18]. This again is also complicated by conceptualisations of depression as a continuing condition, rather than one with clear episodes [19].

Anxiety

There is no consensus on defining relapse in anxiety. Delgadillo and colleagues proposed criteria for measuring relapse in anxiety, requiring three conditions to be met: (a) PHQ-9 and GAD-7 scores below diagnostic cut-offs at treatment completion, (b) at least one score exceeding cut-offs at follow-up, and (c) a statistically reliable deterioration in follow-up scores [20]. Donovan et al. defined relapse using CGI-S (≥4), HAM-A (≥15), or clinician judgment, while others used CGI-S (>2) or a ≥2-point worsening on CGI-BP [21].

Some studies relied on clinician-administered vs. self-reported CGI, despite concerns over clinician subjectivity, while others focused on the return of specific anxiety disorders per DSM criteria, reliable change indexes [22], or symptom re-emergence within 12 months of remission [23].

Areas of Agreement and Tensions in the Field

Agreements

- Hospitalisation is frequently used as a measure of relapse, possibly because it is both easier to measure and more tangible.

Tensions

- Relapse vs. recurrence

The lack of consensus on remission duration means that many recurrences may actually be relapses, raising questions about the need to distinguish between the two in research [18].

- Threshold variability and percentage of increment-based definitions

Schizophrenia: Bighelli and colleagues reported that schizophrenia relapse definitions in trials were so inconsistent that their impact on patient outcomes could not be assessed [24]. Moncrieff et al. noted that *"since 1990, there are almost as many definitions as trials,"* with hospitalisation often used as a proxy despite its limitations [5]. Frequently, relapse is defined based on percentage increases in PANSS scores, although Siafis et al. argue that percentage-based thresholds are problematic for clinically stable patients, where small fluctuations appear disproportionately large—especially at the lower end of the scale. Instead, they recommend using absolute score increases as more reliable indicators, irrespective of baseline severity [9].

Depression: Studies use different thresholds (MADRS ≥ 22 or 18, HAMD ≥ 14 or 16, CGI ≥ 4), with inconsistent application of time criteria. A trial meta-analysis [17] illustrated inconsistencies in rating scale thresholds, timeframes, and proxy indicators. Gleeson et al. and Mangelsdorf et al. emphasise the urgent need for an internationally standardised relapse definition to improve research comparability [25,26].

Interviews and workshop participants noted that numerical thresholds, while providing structure, do not always align with clinical judgment or lived relapse experiences, particularly in conditions where symptom fluctuations are common.

- Multi-factorial criteria

Trials increasingly use multifactorial criteria to define relapse. However, there is little consistency in which criteria are applied most frequently, raising concerns about the reliability of relapse definitions and their applicability in diverse healthcare contexts [5,9]. Workshop participants highlighted that clinician assessments should not override patient-reported experiences of relapse.

- Symptoms vs. functioning

People with lived experience and caregivers highlight declining day-to-day functioning as a key marker of relapse. Workshop participants stressed that a person might experience significant disruptions in work, education, or social life without necessarily showing symptom escalation. While functioning is now included in remission and recovery criteria, it remains largely absent from relapse definitions, creating a critical gap in understanding and addressing relapse.

- Hospitalisation

Workshop discussions highlighted that relapses which impact daily life, work, or relationships but do not require hospital admission were overlooked, and indeed in LICs or contexts where access to formal health care is low, hospitalisation is not always an option. Relapse may instead be better recognised through community or familial observations.

- Limited understanding by PWLE

Interviews and workshops revealed that many PWLE associate relapse with addiction and substance use, rather than with conditions such as depression, anxiety, or schizophrenia. This means that some individuals may not recognise when they are experiencing a relapse in a mental health context, potentially delaying help-seeking. Participants emphasised the need for broader public education to clarify what relapse means across different mental health conditions.

Conclusion

Is further consensus needed?

Yes, we recommend further consensus building for the definition of relapse.

Despite various efforts, there is still no universally accepted definition of relapse across psychosis, depression, and anxiety. Studies use different criteria, making comparisons difficult, and most definitions focus on symptom worsening, overlooking the functional decline which many PWLE consider crucial; a more meaningful definition should include symptoms, functionality, and personal experience. Without greater consensus, research remains fragmented, and clinical decision-making lacks clarity.

What is the priority?

To establish a standardised, widely accepted definition of relapse (for all three conditions covered in this section) to facilitate research comparability, assess treatment effectiveness, and create clinical guidelines.

What are the key barriers and tensions to resolve before consensus is achieved?

There is no agreement on symptom thresholds—should relapse be a full return to diagnostic criteria or a milder worsening? Should relapse be defined by examining both symptoms and functional decline? Studies often apply different rating scales and timeframes, making results incomparable. Hospitalisation excludes people without healthcare access, and it is unlikely that a single method of measuring hospitalisation would be universally applicable.

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9.6 Remission

There is no universally agreed definition of **remission** in mental health. Definitions include symptoms falling below a specific standardised threshold, no longer meeting diagnostic criteria, reduced symptoms that remain below a threshold for a specified duration, complete symptom absence, and improvements based on clinical judgement or functioning [1–3]. Our consultations show that LEEs frequently did not understand the term, had heard it only in the context of conditions such as cancer, and understood it to be a biomedical term.

Table 9.6 Characteristics of the papers reviewed [28]

Publication Year	No. papers	Region	No. papers	Condition	No. papers
2015-2025	38 (40.0%)	Americas	50 (50.5%)	Depression	40 (40.4%)
2004-2014	42 (44.2%)	Europe	43 (43.4%)	Psychosis	33 (33.3%)
1994-2003	12 (12.6%)	Western Pacific	5 (5.1%)	Anxiety	15 (15.2%)
Before 1994	3 (3.2%)	Africa	1 (1.0%)	Trans -diagnostic	11 (11.1%)
		Southeast Asia	0 (0.0%)		
		Eastern Mediterranean	0 (0.0%)		
Totals	**95**		**99**		**99**

28 Table 9.6 indicates the number of papers reviewed on remission and their characteristics. Region of publication refers to either region(s) where the study was conducted or the regional affiliation of the first author. Some papers were allocated to more than one region.
29 Scale for the Assessment of Negative Symptoms. For the full list of abbreviations, refer to section 1, page 3.

Consensus Landscape

Psychosis - Schizophrenia

The RSWG [1] established a consensus definition (cited 3,168 times) which prioritises symptomatic remission while treating functional remission as a separate outcome. They define remission as a mild or lower severity score (≤3) on eight core symptoms of PANSS for ≥6 months [4]. Equivalent thresholds have been established for other scales.

More recently, the Korean Society for Schizophrenia Research [5] proposed a stricter definition: a PANSS score of ≤2 on both positive and negative symptom items, or ≤2 on all items of SANS [29], or a CGI-S score of ≤3, maintained for 12 months; however, this has only been cited 18 times. Conversely, others have suggested a 3-month duration, arguing that clinical trials require more frequent assessments and may not extend long enough to meet the 6- or 12-month criteria [6]. Lack of consensus means that only a few trials use the RSWG criteria and when used, the time criterion is often omitted or changed [7–9].

Definitions vary in how strict they are. The RSWG criteria are less stringent i.e. remitters according to RSWG have lower functioning and higher risk of relapse over time compared to those who are asymptomatic [10]. Other definitions are more stringent [11] but may not be realistic, as very few would reach remission by this definition [11,12].

Other studies show that PANSS-total score (PANSS-T) and PANSS-Positive Negative (PANSS-PN) are more stringent (use more items of PANSS to assess symptom severity) and have greater stability over time [13] but the use of PANSS-T, for example, is time-consuming [14].

There is no consensus definition for functional remission in schizophrenia. In the absence of an agreed definition, various measures are used, of which none have been rated 'high' on usefulness (a score > 8/ 10) by a panel of six experts in schizophrenia [15].

Psychosis - Bipolar

We identified two organised consensus efforts. Hirschfeld et al. proposed remission as minimal or no symptoms of mania and depression for ≥1 week, with sustained remission requiring 8–12 weeks, excluding mixed episodes [16]. The International Society for Bipolar Disorders (ISBD) Task Force defined remission by symptom reduction but treated functioning as a separate outcome and omitted a duration criterion (i.e. a different recommendation on duration from Hirschfeld) [17]. However, the consensus definitions are not consistently used; a recent review of lithium treatment in bipolar depression could not use the ISBD consensus definition as most studies did not provide sufficient details on the definition of remission they used [18].

Functional remission in bipolar is also not well defined. It is measured using several different scales such as GAF or FAST [19,20].

Depression

We identified two seminal definitions that appear to have shaped this term in the field of depression: Frank's (1991) early definition of remission (cited 2,633 times) is *"virtual absence of depressive symptoms,"* operationalised as a HAM-D17 score ≤7, without a duration criterion [3]. Building on this, the ACNP Task Force [21, cited 857 times] established a definition requiring minimal symptoms for ≥3 weeks, lasting up to four months, after which, recovery is defined. However, there has been no universal agreement on this definition of recovery.

Key inconsistencies currently lie in the use of different tools such as HAM-D, Beck's Depression Inventory-II (BDI), or PHQ-9, and non-standardised cut-offs [22]. A recent review of adolescent depression trials identified 47 unique definitions of remission employing a range of tools, cut-off thresholds, and time-points. None of these were co-produced. The differences in cut-offs were explained by the different ways researchers rationalise their use [23]. There is debate over whether a duration criterion is useful: a recent review suggested that remission is best defined as having fewer symptoms than previously, without a duration criterion [24]. There is no consensus definition of functional remission, and it is confused with other terms such as psychosocial functioning, quality of life, or satisfaction [25].

Anxiety

We did not identify a universally accepted definition for remission in anxiety. It is generally defined as no longer meeting diagnostic criteria [26] or scoring below a standardised clinical cut-off [27]. The International Consensus Group on Depression and Anxiety [2] defined remission in panic and social anxiety disorders as almost complete resolution of symptoms across the five domains of panic disorder, maintained for a period of ≥3 months. We identified limited use of this definition, with recent meta-analysis of work in the last five years using varied definitions such as no panic attack for at ≥1 week at the end of study [28] or satisfactory end state as defined by global judgement of the original investigators [29].

Areas of Agreement and Tensions in the Field

Agreements

- Remission is usually measured in relation to symptom severity and most research uses validated tools to quantify symptom severity and operationalise remission.

Tensions

- Functioning

There is disagreement over whether a definition of remission should include functioning. Most identified definitions focus on symptom reduction, but consultation participants and other LEEs emphasise that remission should include functioning [30]. Functional outcomes are associated with symptom reduction, and hence functioning may be assumed if symptoms are measured; without a standard definition of functioning, focus remains on symptom reduction.

- Arbitrary measurements

Because definitions of remission across all conditions of interest are so non-uniform, methods of measuring remission differ widely, ranging from no longer meeting diagnostic criteria, to being below a (variable) cut-off on a range of different measures. Such differences have important implications for pooling data.

- Stringency

More stringent definitions have greater predictive value of remission status over time—but using them means that fewer people are defined as in remission, even if they have mild symptoms. This may result in a downplay of treatment effectiveness and/or in people receiving longer or additional treatments, even though their symptoms are now much less severe. Less stringent definitions have lower predictive value but designate more people as being in remission, which might inflate success rates and paint an overly optimistic picture.

- Time duration

While time duration is considered important in most definitions, the use of duration criteria affects remission rates: the shorter the timespan over which a person needs to show improvement, the more people will meet that criterion. One study showed that defining remission without a time criterion yielded higher remission rates (61% vs.47%) [12]. Such differences in definition create difficulty in accurate comparison of remission following different treatments, and in pooling data. It is unclear as to what extent or duration of remission would be considered ‘good enough’ as a clinical outcome by patients and researchers.

- LEE concerns with the term

LEEs within our consultations stated that remission does not honour the recovery model: it reduces hope by tying the individual to the illness—instead of being recovered they still have the condition, it is just in remission; it ignores functioning which many LEEs consider to be of at least equal importance as symptoms; and most work on definitions arises from high resource settings.

Conclusion

Is further consensus needed?

Yes, we recommend further consensus building for the definition of remission.

Our review and consultations point to major inconsistencies in how remission is defined and measured; functioning is largely absent from the definitional landscape despite its clear importance; the majority of work undertaken on definitions arises from HICs and consensus definitions have little to no lived experience buy-in and ownership.

These have several impacts: people who do not consider themselves remitted are labelled as such, reported rates of remission vary, and research is inadequately representative of the realities of low resource settings.

What is the priority?

High priority.

Remission is a commonly used outcome and without a clear consensus definition that is also consistently applied in research, it is difficult to compare research and its implications.

What are the key barriers and tensions to resolve before consensus is achieved?

Agreement needs to be reached on whether a definition should allow mild or no symptoms at all, and whether to include functioning in the definition of remission. Remission may also depend on treatment-related (adherence) and other social and cultural factors—which are not considered in any of the definitions. Lived experience inclusion in any further consensus work is critical as the definition of remission is historically dominated by a fairly narrow set of perspectives. LE experts highlight that symptomatic remission is often used to discharge people from care which can be unhelpful for people with no access to resources; hence remission needs to be defined according to the availability and accessibility of care.

A first feasible outcome might be the harmonisation of measures and some agreement over cut-off thresholds.

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9.7 Treatment Resistance

The term **treatment resistance** is broadly understood as the failure to show sufficient improvement in symptoms or functioning in response to initiating treatment. However, the term can be understood as referring either to the condition itself being unresponsive to treatment, or to the idea that the person receiving an intervention is unresponsive. While this distinction is rarely clarified in research, our interviews and workshops demonstrated that many PWLE assume that they are being blamed for the treatment failure – they are somehow at fault for not responding to treatment, rather than acknowledging the complexity of the condition or limitations of available treatments. Thus, many PWLE view the term as stigmatising and alienating.

Table 9.7 Characteristics of the papers reviewed [30]

Publication Year	No. papers	Region	No. papers	Condition	No. papers
2015-2025	59 (57.8%)	Americas	46 (45.1%)	Depression	63 (61.8%)
2004-2014	28 (27.5%)	Europe	49 (48.0%)	Psychosis	33 (32.4%)
1994-2003	12 (11.8%)	Western Pacific	4 (3.9%)	Anxiety	6 (5.9%)
Before 1994	3 (2.9%)	Africa	0 (0.0%)		
		Southeast Asia	2 (2.0%)		
		Eastern Mediterranean	1 (1.0%)		
Totals	**102**		**102**		**102**

Consensus Landscape

Treatment-resistant psychosis (TRP)

TRP research largely focuses on the lack of response to medication in treatment-resistant schizophrenia (TRS). Initially, two key criteria were proposed: 2 trials (4 weeks) with different antipsychotics at adequate dosage; <20% reduction in positive symptoms [1]. More recently, TRRIP[31] guidelines [2] suggested: <20% symptom reduction, ≥6 weeks therapeutic dosage, ≥2 past treatment episodes with different antipsychotics, and ≥1 long-acting injectable antipsychotic trial (≥4 months).

Treatment-resistant mania (TRM) has been defined as manic episodes lasting >6 weeks despite treatment with one traditional mood stabiliser and one antipsychotic at therapeutic doses for ≥3 weeks each [3]. The severity of the manic episode(s) is usually assessed using DSM-5 criteria, indicated by a YMRS score ≥18 or MRS score ≥13, favouring an absolute symptom severity threshold rather than a relative reduction in symptoms. This is because the former can be assessed cross-sectionally, while a relative percentage change requires a baseline assessment [3]. This is more stringent than a previously suggested definition, which required no reduction in mania scores or increase in depression scores over an 8–10-week treatment period [4].

Treatment-resistant depression (TRD)

We identified several TRD definitions, all concerning pharmacotherapy resistance:

- Failure of two adequately-dosed antidepressant treatments of 4–8 weeks with adequate [32] adherence [5].

30 Table 9.7 indicates the number of academic published papers reviewed on relapse reviewed and their characteristics. Region of publication refers to either the region where the study was conducted or the regional affiliation of the first author.
31 Treatment Response and Resistance In Psychosis. For the full list of abbreviations, refer to section 1, page 3.
32 Adequate dose is typically defined based on standardised therapeutic ranges (e.g., per FDA or EMA guidelines), but this varies by medication and study criteria. Adherence may be assessed through self-reports, pill counts, electronic monitoring, or pharmacy records (and see the Landscape on 'adherence'), though many definitions of TRD do not specify an assessment method.

- <25% reduction in major depressive disorder severity after trials of ≥2 antidepressants, either with a drug-free interval, sequential switching (both failing), or augmentation where the second drug also fails [6].

- Failure to respond; non-response is <50% symptom reduction with two adequately-dosed and evidence-supported antidepressants over 4–6 weeks [7].

- Failure to respond to two evidence-based SSRI antidepressants at adequate dosage/duration combined with psychotherapy [8].

- The Food and Drug Administration (FDA) [9] and European Medicines Agency (EMA) criteria describe TRD as failure to respond to ≥2 antidepressant treatments despite adequate dose, duration, and adherence. Revised EMA guidelines state that patients with 1 failed maximum dose treatment of adequate duration are also considered TRD [10].

The most common research definition of TRD is the failure to respond to two antidepressants from different pharmacological classes for 4–6 weeks [11–13]. Staging models (which conceptualise depression not as a single, uniform condition, but as a disorder that progresses through identifiable stages over time) classify TRD on a spectrum, categorising resistance into stages [14].

The term TRD has been criticised for being stigmatising and pessimistic; efforts to reframe it include terms like pharmacotherapy-resistant depression [5] and difficult-to-treat depression [15]. However, none are commonly used in research and the term difficult-to-treat was not considered any less stigmatising than treatment-resistant by our experts, stating that it can still be construed as the person being difficult-to-treat.

Treatment-resistant anxiety (TRA)

Two recent consensus efforts for TRA were identified:

- One review found that 60% classified resistance after one failed trial, concluding that one pharmacological failure and one psychological failure each lasting ≥8 weeks, with a minimum persistent anxiety severity constituted TRA [16].

- A Delphi consensus guideline suggested that one failed psychotherapy trial or two failed pharmacotherapy trials, with treatment durations of 6–8 weeks for medication and 12–20 weeks for psychotherapy, constituted TRA. Non-response was defined as <50% reduction in HAM-A or BAI scores or a CGI-I score >2, with optional GAD criteria including a <4-point reduction on GAD-7 or PSWQ [17].

The inclusion of psychological interventions in recent definitions of TRA is not found in depressive or psychotic disorders.

Areas of Agreement and Tensions in the Field

Agreements

- Emerging standards

Standardisation efforts include the research inclusion algorithm [33] [6] and the reporting checklist [34] [2]. However, insights from interviews and workshops indicate that a definition incorporating psychosocial and LE perspectives, as well as biomedical ones, is needed to avoid a contested and inconsistently applied concept.

33 The research inclusion algorithm (Sforzini et al., 2022) establishes standardised criteria for defining TRD and partially responsive depression (PRD) in clinical trials, specifying treatment failure thresholds, adequate dosing/duration, adherence assessment, and exclusion criteria to ensure consistency in participant selection and regulatory alignment.

34 The reporting checklist, as per Howes et al. (2022), may be useful for standardising the definition and assessment of treatment resistance across studies, improving comparability and reproducibility of research findings. It also accounts for pseudo-resistance, where a patient appears treatment-resistant, but the lack of response is actually due to factors such as poor adherence, incorrect diagnosis, inadequate medication dosing or duration, drug interactions, or psychosocial influences, rather than biological resistance. By incorporating adherence and other confounding factors, the checklist helps differentiate true treatment resistance from alternative factors.

- Treatment trial criteria

Treatment trials should meet minimum standards for dosage, duration, and adherence, but these parameters are often unclear.

Tensions

- Terminology concerns

The term treatment-resistant is seen by many PWLE as punitive and stigmatising, making individuals feel blamed for poor treatment response.

Disagreement around interpretations of the term include viewing resistance as a biological non-response or the reluctance to engage with treatment, leading to miscommunication. This is problematic, particularly for individuals who respond well to some treatment modalities but not to others.

Alternative terms suggested included treatment mismatch, although mismatch may imply that there is a correct match. Workshop participants advocated for definitions that emphasise treatment inadequacy rather than individual failure, in order to shift responsibility onto systems rather than individuals.

- Use of multiple definitions

Key areas where research definitions diverge include:

a) minimum number of treatment failures—consensus definitions and guidelines commonly converge but the number varies in real-world research.

b) drug classes —there is no agreement on whether TRD involves the same antidepressant class. Regulatory discrepancies complicate clinical decision-making [7]. Workshop participants raised concerns that TRD definitions may be influenced by pharmaceutical interests, favouring criteria that align with specific products.

c) definition of non-response—no consensus exists on non-response in depression and anxiety. Many studies do not define non-response; those that do use definitions ranging from 25–50% symptom reduction [16]. Non-response may indicate no effect, inadequate effect, or minimal effect. Participants emphasised the need to assess functional outcomes; definitions often ignore psychological and social interventions.

d) a 4-week duration may be considered inadequate, even though fast-acting antidepressants may be effective within a shorter duration.

e) inclusion (or not) of treatment history.

f) to classify as TR, a person must have adhered to the treatment regime, yet adherence remains poorly defined, using vague terms such as ‘adequate’ adherence. While TRRIP guidelines offer operational criteria [2], most studies assess only pharmacological treatments, failing to consider psychological or social factors influencing engagement [18]. Participants argued that non-adherence implies that patients resist treatment, but there may be other reasons for non-adherence like systemic barriers, side effects, or treatment appropriateness.

- Western focused

Research largely emanates from HICs, and treatments prescribed in these contexts may not be available or affordable in LMICs or low resource settings. Additionally, social determinants and psycho-social interventions are overlooked, which may be more appropriate in LMICs.

- Psychological treatment integration

The inclusion of psychological treatments in defining treatment resistance is debated, particularly in depression where they are often first-line interventions [17]. Their inclusion may complicate definitions and regulatory policies, but MH and LE experts advocate for their recognition.

- Poor emphasis on functioning

Definitions prioritise symptom reduction, overlooking patient-centred outcomes like quality of life and functional recovery. Workshop participants argued that existing treatments fail to address employment, social engagement, and relationships. Participants questioned whether lack of symptom reduction alone is appropriate to define treatment resistance, as individuals may report positive changes in quality of life, or functioning, which might suggest that their condition is not treatment resistant.

- Limited term usage in community health settings

Treatment resistance is rarely used in community health settings, partly due to its biomedical framing. Interviews and workshops indicated that service users and non-medical practitioners perceive the term as implying failure on the individual's part rather than highlighting treatment limitations, reinforcing stigma. Practitioners in non-Western and low-resource settings also noted the lack of culturally relevant terminology and called for more inclusive, person-centred language to improve communication and care accessibility.

Conclusion

Is further consensus needed?

Yes, we recommend further consensus building for the definition of treatment resistance.

The definition remains inconsistent within and across conditions, with criteria variations including treatment duration, adherence, and response thresholds. The term itself is contested, with concerns about its stigmatising nature and exclusion of psychological treatments. Definitions are shaped by HICs and high resource perspectives, affecting clinical decision-making, research comparability, and regulatory approvals.

What is the priority?

High priority.

Achieving a clearer, more inclusive definition of treatment resistance (for all three conditions covered in this section) is vital—it directly impacts on treatment pathways, regulatory decisions, equity, access to care, and mental health research.

What are the key barriers and tensions to resolve before consensus is achieved?

Clarity over whether empirical evidence supports one definition over another. Universal agreement has not been possible because of the ever-changing landscape of mental health treatments; there is reluctance to impose a rigid definition. The term does not resonate with LEEs and balancing all perspectives will be challenging. Treatment resistance is linked to medical claims, access to certain treatments, and even access to euthanasia in some countries — serious real-world implications.

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Terms for which we do not recommend further consensus development

9.8 Comorbidity

The 1970's definition of **comorbidity** in general medicine has stood the test of time: "*the co-occurrence of distinct conditions alongside a primary illness*" [1]. In mental health it has since evolved to encompass both the co-occurrence of medical and psychiatric disorders, and the co-occurrence of multiple psychiatric disorders. The concept has also generated other related concepts and terms:

- Dual-diagnosis (concurrent) disorders: The concept emerged when clinical issues increasingly arose related to patients with substance use disorders also having significant mental health issues [2].

- Co-occurring disorders: Introduced as a putative replacement for dual diagnosis in order to move away from an overly medicalised focus on diagnosis [2].

- Related terms include multimorbidity, cosyndromality and consanguinity (conditions so closely related they should be considered as one disorder) [3].

As well as several terms, there are many inconsistencies in definitions, arising from ambiguity over index versus secondary condition, chronology of the conditions, and whether they intersect with each other, and if so, how. Given this, our expert consultations revealed that a universal definition would be both difficult and unhelpful to operationalise.

Table 9.8 Characteristics of the papers reviewed [35]

Publication Year	No. papers	Region	No. papers
2015-2025	20 (47.6%)	Americas	18 (42.9%)
2004-2014	13 (31.0%)	Europe	15 (35.7%)
1994-2003	6 (14.3%)	Western Pacific	9 (21.4%)
Before 1994	3 (7.1%)	Africa	0 (0.0%)
		Southeast Asia	0 (0.0%)
		Eastern Mediterranean	0 (0.0%)
Totals	**42**		**42**

Consensus Landscape

At least 12 types of comorbidities exist (psychiatric and physical, substance misuse and other psychiatric, two types of psychiatric, two types of physical etc) [4–8], but several frameworks have been suggested to develop a more nuanced picture. Nordgaard and colleagues argue that the concept of psychiatric comorbidity is useful but lacks a solid theoretical basis and is applied too liberally [6]. They propose a refined framework for understanding and diagnosing psychiatric comorbidity, suggesting two principles to improve assessment. The first principle is to distinguish between a trait and a state condition to identify whether the two conditions are independent. Trait conditions are enduring, long-standing disorders whose symptoms persist over years; state conditions are episodic

35 Table 9.8 indicates the number of published academic papers reviewed on comorbidity reviewed and their characteristics. Region refers to either region(s) where the study was conducted, or the regional affiliation of the first author.

disorders that unfold during discrete, time-limited episodes. In practice, if a patient presents with symptoms of schizophrenia and depression, Nordgaard and colleagues suggest intervening with depression first, and if depression does not recede, then diagnosing schizophrenia. The second principle is to reemphasise the hierarchy of illnesses, meaning that a comorbid diagnosis should not be assigned if the symptoms can be fully explained by the primary disorder.

The HiTOP[36] model offers a dimensional framework in research for understanding mental health conditions, including comorbidities in schizophrenia and other psychoses [9]. HiTOP conceptualises mental health issues as existing on a spectrum, ranging from mild to severe symptoms; these dimensions are grouped into broader categories called spectra, which include thought disorder, disinhibition, antagonism, somatoform, and core internalising. It has been argued that the model has significant clinical relevance for understanding and addressing comorbidities in schizophrenia, by adopting a spectrum-based perspective [10]. The syndemic framework emphasises the interactive and synergistic relationships between health conditions, showing how biological, socio-cultural, and environmental factors collectively influence the onset, progression, and outcomes of illnesses. Unlike traditional approaches that isolate diseases, this framework adopts a systemic and intersectional perspective, demonstrating that conditions actively interact, compounding each other's effects [11].

36 Hierarchical Taxonomy of Psychopathology. For the full list of abbreviations, refer to section 1, page 3.

Areas of Agreement and Tensions in the Field

Agreements

Comorbidity generally refers to the simultaneous presence of two conditions; any combination of mental health disorders, substance use disorders, and physical diseases.

Tensions

- Grouping of conditions

There is ambiguity over what might be included in the grouping of two (or more) conditions: two mental health conditions, a mental health condition with a substance condition, or a mental health condition with a physical condition? Different researchers and clinicians use different definitions to decide whether these are in fact co-morbidities.

- The nature of conditions

When there is agreement that two conditions meet the requirement to be termed co-morbid, a second level of difference emerges: are the two conditions independent, or are they related; is one a precursor of the other, or is one a sub-set of symptoms of a primary index condition; do they have a bi-directional relationship where each one causes the other one to get worse, etc. The approach taken is usually based on the conditions of interest and the evidence-base for the relationship between those conditions. Our experts highlighted that most mental health conditions share mechanisms and processes, suggesting that it is difficult to think of any non-interacting mental health problems.

Both in our workshops, and in the research we reviewed, comorbidity between depression and anxiety was described as interactive, having a bidirectional relationship that increases the other's risk [12]. In conditions such as hypertension and anxiety, comorbidity was described as co-existence [13]. In conditions such as borderline personality disorder (BPD) and depression, the personality disorder is often described as the index condition and the other as the comorbid condition whose treatment should be de-prioritised in comparison to BPD-specific treatment [14]. A recent meta-analysis suggested that anxiety and depression can be precursors of psychosis, and as a result, that transdiagnostic interventions are needed for at-risk individuals [15].

These issues complicate clinical trials and mental health services, both of which often exclude individuals with comorbidity—even though symptoms may be overlapping or precursors to a condition. Nevertheless, we do not consider this a problem with the concept and definition of co-morbidity, rather a problem with the inclusion/exclusion criteria of trials or services.

- Overdiagnosis

Concerns have been raised that comorbidity diagnoses lead to overdiagnosis, already identified as an issue within mental health [16]. Interestingly, some experts emphasise the practical significance of overdiagnosis in increasing access to healthcare, accessing insurance, and accessing treatment funding.

Conclusion

Is further consensus needed?

No, we do not recommend further consensus building on defining comorbidity.

Insights from desk-based research and consultations point to a key issue: the diversity in conceptualising and using comorbidity in practice is a strength, fostering better understanding of mental health conditions, and its use should not be made static. Many experts stated that comorbidity is an umbrella term, and that there are many valid definitions; selecting one meaning from the myriad meanings that exist would be unhelpful.

A more practical approach would be to embrace this variability while ensuring that each use of the term is clearly explained. This would enhance communication in research, improve grant proposals, facilitate collaboration across disciplines, and support the development of ideas.

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9.9 Drug-Induced

Drug- or substance-induced conditions are defined as arising during or soon after substance use, withdrawal, or discontinuation, producing symptoms of psychosis, depression, or anxiety. Due to the term being defined in diagnostic classifications, we do not recommend that further consensus building on clarifying the definition is warranted.

Table 9.9 Characteristics of the papers reviewed [37]

Publication Year	No. papers	Region	No. papers	Condition	No. papers
2015-2025	33 (68.8%)	Americas	15 (31.3%)	Depression	3 (6.3%)
2004-2014	12 (25.0%)	Europe	23 (47.9%)	Psychosis	37 (77.1%)
1994-2003	3 (6.3%)	Western Pacific	2 (4.2%)	Anxiety	0 (0.0%)
Before 1994	0 (0.0%)	Africa	0 (0.0%)	Bipolar	2 (4.2%)
		Southeast Asia	4 (8.3%)	Mania	1 (2.1%)
		Eastern Mediterranean	4 (8.3%)	Transdiagnostic	5 (10.4%)
Totals	**48**		**48**		**48**

37 Table 9.9 indicates the number of published academic papers reviewed on drug-induced and their characteristics. Region refers to either region(s) where the study was conducted or the regional affiliation of the first author.

Consensus Landscape

Key, existing definitions are derived from the diagnostic classifications of the ICD-11 [1] and the DSM-5 [2], which continue to be used in systematic reviews and trials.

Definitions of drug- (or substance-) induced

In ICD-11, substance-induced refers to psychological, cognitive, or behavioural symptoms that occur during or soon after using, withdrawing from, or stopping a substance. These symptoms are typically more severe and last longer than the effects of the substance, as specified in ICD-11. DSM-5 defines substance-induced disorders as serious but usually temporary conditions caused by substances, medications, or toxins. The key features include: a) the condition develops during or soon after intoxication, withdrawal, or use/discontinuation of a specified substance or psychoactive medication, b) each specified substance and its amount/duration of use produce the corresponding symptoms (anxiety, depression, or psychosis), c) symptoms are not better explained by another mental health problem, d) no evidence for a different diagnosis, such as symptoms persisting long after cessation, e) symptoms result in significant distress or impairment in personal, family, social, educational, or occupational areas. If functioning is maintained, it requires significant additional effort.

Anxiety

Symptoms include apprehension, worry, fear, physiological symptoms, panic attacks, and avoidance behaviour. While anxiety and its co-occurrence with substance use is well researched and clinically acknowledged, literature on substance-induced anxiety is sparse [3].

Depression

Symptoms involve depressed mood changes, decreased engagement in pleasurable activities, and altered energy levels. The lifetime prevalence of substance-induced depressive disorders is estimated to range between 0.26–1% [4, 5], as compared to an overall lifetime prevalence of depressive disorder of 26% [6].

Psychosis

Symptoms are characterised by features such as delusions, hallucinations, disorganised thinking or behaviour, and highly elevated mood. Substance-induced psychosis (SIP)[38] presents significant challenges in terms of definition and diagnosis, primarily due to its complex relationship with primary psychotic disorders and the diverse range of substances that can induce psychotic symptoms. It can mimic primary psychotic disorders, making differential diagnosis challenging. One in four people with substance-induced psychosis transition to schizophrenia-spectrum disorder [7].

The potency and type of substance can influence the severity and type of psychotic symptoms, complicating the diagnostic process.

Areas of Agreement and Tensions in the Field

Agreements

- Research on drug-induced conditions use diagnostic classification criteria to identify people with substance-induced conditions.
- There is broad agreement in research into substance-induced conditions regarding the temporal relationship between substance use and mental health conditions.

Tensions

- Substance-induced implies causality

Substance-induced mental health problems are explicitly associated with causality. However, assuming that a temporal connection between drug use and symptoms such as anxiety, depression, or psychosis is sufficient to establish causation oversimplifies the broader Bradford–Hill criteria for causality [8]. Multiple factors, such as causal precedence, the effect, consistency of association, replicability of findings, strength of the relationship, study robustness, and convergence of multiple lines of evidence must be considered [9]. Our MHEs and LEEs raised numerous issues, suggesting that underlying vulnerabilities, genetic predisposition, or environmental stressors were all possible contributors to the co-existence of mental health and substance use problems.

Diagnostic labelling carries consequences for treatment access, and some argue for more neutral terminology such as substance-related or substance-associated [10].

- Misclassification, and persistent states of substance-induced conditions

There is debate around the distinction between substance-induced disorders and primary disorders. Many individuals initially diagnosed with substance-induced psychosis later develop schizophrenia or other psychoses [11,12]; a recent meta-analysis showed a pooled transition rate of 25% across all substances [7]. Persistent or chronic states of substance-induced conditions are not well accounted for in current criteria and literature. Diagnostic criteria refer to acute effects,

38 Substance-induced psychosis. For the full list of abbreviations, refer to section 1, page 3.

not a longer-term shift in mental state which continues well beyond the cessation of a substance. It is known that some individuals continue to experience substance-induced symptoms months or years after cessation [13]. Project participants noted that the assumption that conditions are transient may result in suboptimal psychiatric care.

- Differences in diagnostic classifications

According to DSM-5, psychotic symptoms combined with recent substance use suffice for a diagnosis. In contrast, ICD-10 and ICD-11 require psychotic symptoms to be significantly more severe than those expected from the substance's effects or withdrawal. Project interviewees stated that such differences lead to the inconsistent application of diagnoses across clinicians and regions, issues further complicated by under-diagnosis, patients' non-disclosure and the stigma around substance use. It is unknown to what extent this difference in definition impacts research [14].

- Western focused

There is limited research on substance-induced conditions in low-resource settings [7]; such conditions may present and appear very differently in such circumstances.

Experts from low-resource settings also stated that patterns of substance use, and mental health conditions differ markedly in different sociocultural and political contexts, and that this has ramifications for undertaking research.

In areas where the use of substances is taboo, funding and research are limited. Similarly, in cultures where discussing mental health issues or substance use is taboo, there will be significant under-reporting and a lack of research focus. On the other hand, experts commented that since the prevalence of substance use varies enormously between settings, the extent to which this is a regional priority also varies.

Conclusion

Is further consensus needed?

No, we do not recommend further consensus building on defining 'drug- or 'substance-induced'.

These terms are well-defined in diagnostic classifications, and DSM and ICD criteria are readily adopted in research and clinical practice. However, their use in research and practice raises challenges around causality, misclassification, and persistent symptoms beyond withdrawal. Despite these tensions, further consensus-building may not be fruitful unless there are attempts to change the 'substance-induced' classification in diagnostic systems, which largely dictates research in this domain. This is beyond the scope of this project.

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9.10 Early Intervention

A recognised concept in mental health, **early intervention** is broadly defined as intervening in the early stages of a condition. The term has been widely adopted in psychosis studies [1], with increasing use in depressive and anxiety disorders [2–4]. There is broad agreement that intervening early can significantly improve long-term outcomes; however, confusion remains around the definition of the term early, as well as regarding interchangeable use of the terms prevention, early intervention, and early-life interventions. This term was included because both LEEs and MHEs highlighted it as a priority for research and practice and considered that the confusions over definitions were detrimental.

Table 9.10 Characteristics of the papers reviewed [39]

Publication Year	No. papers	Region	No. papers	Condition	No. papers
2015-2025	52 (85.2%)	Americas	26 (42.6%)	Depression	4 (6.6%)
2004-2014	6 (9.8%)	Europe	21 (34.4%)	Psychosis	40 (65.6%)
1994-2003	3 (4.9%)	Western Pacific	10 (16.4%)	Anxiety	5 (8.2%)
Before 1994	0 (0.0%)	Africa	1 (1.6%)	Bipolar	5 (8.2%)
		Southeast Asia	3 (4.9%)	Borderline	1 (1.6%)
		Eastern Mediterranean	0 (0.0%)	Transdiagnostic	6 (9.8%)
Totals	**61**		**61**		**61**

Consensus Landscape

Definitions of Early Intervention

While there is broad agreement that early intervention refers to a set of strategies and interventions aimed at identifying and addressing mental health concerns at an early stage, exactly how the term early is defined remains elusive. Guidelines, Delphi consensus studies, reviews, and randomised controlled trials have identified several definitions [5–10], including:

- delivering preventive programs to young populations to enhance socio-emotional development and reduce future severe disorders.
- identifying at-risk individuals and intervening early to prevent full-blown disorders.
- targeting early signs and symptoms of mental health issues.
- identifying and providing specialised treatment to individuals experiencing their first episode.

Psychosis

Early intervention in psychosis has been extensively studied. While early intervention generally implies that symptoms or signs of the disorder are already present, it is conceptualised in two ways to target distinct populations. The first focuses on individuals who have recently experienced a first psychotic episode, focusing on reducing the duration of untreated psychosis (DUP) and providing support in the first few years of the disorder to reduce the risk of chronic psychosis. The second focuses on individuals with clinical high risk (CHR)[40] or ultra-high risk (UHR) status; individuals exhibiting functional decline or symptoms indicative of an increased risk of developing psychosis [11].

39 Table 9.10 indicates the number of academic published papers reviewed on early intervention and their characteristics. Region refers to either region where the study was conducted or the regional affiliation of the first author.
40 For the full list of abbreviations, refer to section 1, page 3.

The first conceptualisation – those who have recently experienced a first psychotic episode – overlaps with a definitional challenge examined above, related to defining first-episode psychosis itself (see the landscape on first episode, 9.2). There is no universal agreement on what qualifies as a first psychotic episode; some definitions stringently require symptoms that meet formal diagnostic criteria, a minimum symptom duration, and no influence from substance use or other comorbidities; others take a broader, more inclusive approach, considering even a brief period (e.g. one week) of distinct psychotic symptoms as a first episode, even in the presence of substance misuse or other mental health conditions [12].

Most research into early intervention services focuses on this first definition; attempting to prevent chronic psychosis in those who are recently diagnosed. One recent review of such services explicitly excluded individuals in the CHR, UHR, or prodromal phases [13]. This aligns with the framing of early intervention in psychosis as early secondary intervention—reducing treatment delays and providing care in the early stages of a condition [14,15].

However, there is growing interest in the latter definition; developing different early interventions, aimed at at-risk individuals before onset, so-called indicated prevention [14]. This raises a fundamental question regarding whether one definition of early intervention can encompass these differences; should early intervention remain limited to post-onset interventions, or should it also include preventive efforts targeting high-risk populations. At the moment, in conditions like schizophrenia and bipolar disorder, early intervention includes both indicated prevention (identifying and supporting high-risk groups) and treatment post-onset, to speed recovery and reduce chronicity.

Furthermore, there is significant variability in how long early intervention services should last. While durations range from 2–10+ years [16], existing evidence suggests that a minimum intervention of two years provides meaningful benefits [17].

Depression and Anxiety

Early intervention in the context of depression and anxiety is less structured, as early symptoms (e.g., mood fluctuations) often overlap with other conditions [18,19]. It is often framed as indicated prevention, targeting people with symptoms below a diagnostic threshold or before the problem becomes serious [20–23]. It includes targeted interventions for at-risk individuals, although in reality there is also often overlap with universal prevention programmes [9–10].

Confusions arise from the interchangeable use of the terms early intervention and prevention intervention, as well as the inclusion within the term early intervention of early-life or prevention programmes, delivered soon after birth [10,24].

Areas of Agreement and Tensions in the Field

Agreements

There is broad agreement across research, clinical practice, and lived experience perspectives that early intervention means providing intervention as soon as possible in the course of a condition. There is similar broad agreement that the nature of such an early intervention should not be a fixed, one-size-fits-all, standard across conditions or individuals; instead that it should remain a flexible concept, shaped by clinical thresholds, symptom progression, and service availability.

Tensions

Alternative and different meanings for the term

A key tension relates to the different meanings that researchers and others apply to the same term. As shown above, the term early intervention comprises at least four areas in addition to early-life interventions: a secondary intervention for those already diagnosed with a condition; an indicated prevention with those who are showing signs or symptoms at pre-diagnostic levels; a selected prevention for those with no signs or symptoms but who are known to be at risk from other factors; and a universal prevention within specific populations (such as post-partum mothers or children in deprived areas) or within entire populations to reduce the chances of people later developing a condition.
Nevertheless, despite this definitional variability the available evidence does not indicate that definitional variance hinders research in mental health.

Conclusion

Is further consensus needed?

No, we do not recommend further consensus-building on defining early intervention.

While there is no universal agreement on its scope and definition, and mental health and lived experience experts stress the importance of differentiating intervention timelines, strategies and modalities across conditions, existing literature does not indicate that definitional variance impedes research or the development of effective interventions, if the definitions used are clearly defined and articulated.

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9.11 Mechanism

The concept of **mechanism** has become increasingly popularised in mental health research and has roots in various disciplines, including neuroscience, biology, and implementation science. This term was reviewed in the project because it is highly ambiguous and context dependent. There are disagreements over whether mechanisms are biological, social, or psychological, and whether they represent processes or outcomes. It was the least familiar term among our LEEs but conceptually regarded by MH experts as highly impactful in research to understand what works, for whom, and why.

Table 9.11 Characteristics of the papers reviewed [41]

Publication Year	No. papers	Region	No. papers
2015-2025	29 (96.7%)	Americas	10 (33.3%)
2004-2014	1 (3.3%)	Europe	13 (43.3%)
1994-2003	0 (0.0%)	Western Pacific	6 (20.0%)
Before 1994	0 (0.0%)	Africa	0 (0.0%)
		Southeast Asia	1 (3.3%)
		Eastern Mediterranean	0 (0.0%)
Totals	**30**		**30**

41 Table 9.11 indicates the number of academic published papers reviewed on mechanism their characteristics. Region refers to either the region where the study was conducted or the affiliation of the first author.

Consensus Landscape

There is no singular consensus definition on what counts as a mechanism across different disciplines and study designs. This is the case across research and practice within psychosis, depression, and anxiety, and as such the review below is not condition specific.

We did not identify any systematic review that lists the different definitions of mechanism used in mental health research.

Perspectives or definitions of mechanism

The term mechanism is understood in various ways, including:

- Biology: philosophical mechanism—a philosophical idea about the nature of life and biology; a machine mechanism which refers to the internal workings of a machine or a machine-like structure, or a causal mechanism which explains how a particular phenomenon comes about by identifying the processes or events that link cause and effect [1].

- Social science: James Mahoney grouped definitions into four types: a) mechanism as synonymous with the cause of an outcome; b) mechanism as an intervening process, event, or variable, c) mechanism as underspecified causal propositions that can be applied to a fairly wide range of cases, and d) mechanism as an unobserved entity that generates an outcome [2].

- Implementation science: a process or event through which an implementation strategy operates to affect desired implementation outcomes [3].

- Realist evaluations: mechanisms are usually hidden, context-dependent, and responsible for the outcomes [4,5].

- Neuroscience: the fundamental goal of research in neuroscience is to uncover the causal structure of the brain [6]. The term mechanism in neuroscience suffers from a lack of clear, consistent definition across different studies and contexts [6]. In recent neuroscience and pharmacology trials, mechanism is defined as how and why a treatment works; 5-HT2A receptors mediating the psychedelic effects of psilocybin [7]; therapeutic mechanisms through which drugs work using network pharmacology methods [8, 9]; observation—where mechanisms are treated as mediators [10]; neural mechanisms through which drugs impact an outcome [11].

- Psychology: where researchers examine mechanisms of change in relation to various psychological treatments [12, 13].

- Funders: The NIH[42] (USA) defines mechanistic clinical trials as studies aimed at understanding biological or behavioural processes, disease pathophysiology, or intervention mechanisms in humans, distinguishing them from efficacy trials; they have clear criteria regarding what counts as mechanism of action [14]. The National Medical Health and Research Council (NMHRC, AUS), while not explicitly defining mechanism, has a broader scope supporting research into the mechanisms behind diseases [15,16]. The National Institute for Health Research (NIHR, UK) has a broad focus on mechanistic studies but excludes biomarker discovery [17]. Wellcome takes a broader approach: mechanisms at the atomic, molecular, or psychosocial level, and in the use of metaphors such as active ingredients that indicate multiple influencing factors in anxiety, depression, and psychosis outcomes [18].

42 National Institutes of Health. For the full list of abbreviations, refer to section 1, page 3.

Areas of Agreement and Tensions in the Field

Agreements

- Mechanisms operate at different levels, and a holistic understanding of mechanisms is required to effectively intervene within mental health.

Tensions

- Alternative and different terminologies

Mechanisms, mediators, moderators, and pathways are terms used in tandem in mechanism research, where the difference in meaning is ambiguous [19, 20]. It is often unclear if mediators and/or moderators are being seen as mechanisms. The differences, if any, between mechanisms and pathways is also unclear.

MH and LE experts highlight that the standalone term ‘mechanism’ is confusing and needs clarification or expansion, depending on its use. It could refer to different contexts like action, pathogenesis, or psychological mechanisms; depending on context, it could mean the mechanism of action for medications, the mechanism of symptom development, or the mechanisms underlying the development of disabilities. Moreover, it extends to understanding how treatment modalities, including psychological interventions, function—essentially, what mechanisms drive their effectiveness.

- Lack of cross-disciplinary communication

Experts highlighted that mental health conditions have complex origins shaped by biological, psychological, social and other factors. However, researchers from these different fields are often not engaging with one another, leading to a disconnect. Both our reviews of the literature and insights from our consultations suggest that this lack of communication,

rather than a lack of consensus on the definition, appears to be the bigger issue, across mental health research, clinical practice and policy. For instance, adverse childhood experiences as a mechanism for the development of depression is radically different to serotonin receptors as a mechanism for the development of depression.

Conclusion

Is further consensus needed?

No, we do not recommend further consensus building on defining the term mechanism.

Our desk-based research and consultations indicate that the diversity in how mechanisms are theorised and used in practice is a strength that fosters better understanding of mental health conditions and its use should not be made static. Experts argued that *"if everyone agrees, there is no innovation"*. Maintaining some level of flexibility in the use of the term encourages diverse approaches and new insights rather than imposing rigid definitions.

A more practical approach would be to ensure that each use of the term is clearly explained. This would enhance communication in research, improve grant proposals, facilitate collaboration across disciplines, and support the development of ideas [6].

> This is a very broad term, and it can be used for many different things – mechanisms of a disorder for instance. When I use the term 'mechanism,' I refer to how psychotic symptoms or disorders occur, whether psychologically or biologically. How does a psychotic episode or disorder manifest? What's the biological mechanism? Is it related to dopamine hypersensitivity or overactivity in certain parts of the brain? Environmental mechanisms are also significant. For example, ethnic minorities have an increased risk for psychosis. The mechanism there seems to be related to social exclusion or minority status. There are many different ways to use the word mechanism"
>
> *– Mental health expert, interview*

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9.12 Prodrome

The concept of **prodrome** aligns with staging models, the longitudinal development of psychiatric disorders and temporal disorder progression. Broadly, the term refers to early signs or symptoms preceding the definitive onset of a disorder. It is primarily used in psychosis and was the least familiar term among our research participants. LE and MH experts considered the term retrospective and pessimistic, suggesting inevitable progression to psychotic disorder [1] —an outdated concept.

Table 9.12 Characteristics of the papers reviewed [43]

Publication Year	No. papers	Region	No. papers	Condition	No. papers
2015-2025	77 (61.4%)	Americas	35 (27.8%)	Depression	12 (9.5%)
2004-2014	37 (29.4%)	Europe	51 (40.5%)	Psychosis	68 (54.0%)
2003- 1994	9 (7.1%)	Western Pacific	16 (12.7%)	Anxiety	5 (4.0%)
Before 1994	3 (2.4%)	Africa	0 (0.0%)	Bipolar	22 (17.5%)
		Southeast Asia	6 (4.8%)	Transdiagnostic	19 (15.1%)
		Eastern Mediterranean	1 (0.8%)		
		Multiple	16 (12.7%)		
		Global	1 (0.8%)		
Totals	**126**		**126**		**126**

Consensus Landscape

Prodrome is an umbrella term which was historically applied retrospectively, making it suboptimal for early identification and intervention. Recent conceptualisations focus on prospective identification and use the concepts of ultra-high risk [UHR] [44], clinical high risk [CHR], or at-risk mental states [1–3].

Psychosis

Definitions of prodrome onset (when the first subtle, non-specific symptoms appear) include:

- first noticeable illness,
- first somatic or psychological symptom,
- and first contiguous attenuated positive or negative symptom.

Definitions of the end of prodrome (the point at which clear, diagnosable symptoms of the full disorder emerge) include first psychotic symptom and first hospitalisation for psychosis [4].

Benrimoh and colleagues categorised definitions into three groups:

- "*Specified broad ways*", which include explicit symptoms or diagnostic criteria encompassing but not limited to sub-threshold psychotic symptoms
- *"Broad and underspecified ways"*, including "the earliest clinically significant deviation from the patient's premorbid personality, established considering the first appearance of either attenuated positive or negative symptoms"
- and "Sub-threshold" psychotic symptoms [5].

43 Table 9.12 indicates the number of published academic papers reviewed on prodrome and their characteristics. Region refers to either the region(s) where the study was conducted or the regional affiliation of the first author.
44 For the full list of abbreviations, refer to section 1, page 3.

Another way of grouping definitions is:

- time-oriented definitions, e.g., the early period leading up to psychosis onset [6], the time interval between prodromal symptom development and the onset of the characteristic manifestations of the fully developed illness [7], and symptoms antedating the onset of the full-blown episode fixed by ≤6 months [8]
- symptom-oriented definitions, e.g., appearance of the first basic symptom [4], or early signs and symptoms of illness occurring before the onset of the characteristic manifestations of the disease [9]
- and those that use the term prodrome but actually describe the prospective concept of CHR.

Current literature rarely references the term prodrome, arguing that it lacks a clear and prospective definition; indeed, our participants stated that the term prodrome is no longer commonly used, and that the preferred term is CHR [10] or UHR. CHR considers multiple factors to determine the level of risk in a group. These include a) attenuated psychotic symptoms; b) brief, limited, intermittent psychotic episodes (BLIP); and c) presumed genetic risk with significant psychosocial decline [11]. Those at CHR are commonly assessed using measures including the Comprehensive Assessment of At-Risk Mental States (CAARMS) [3] or the Structured Interview for Prodromal Syndromes (SIPS) [12]. These assessment tools are consistently used [13] and CHR criteria are the most widely used in the literature [14].

A new transdiagnostic framework has recently been introduced which extends beyond the UHR category—Clinical High At Risk Mental State (CHARMS) [15]. This comprehensively defines a syndrome requiring treatment due to symptom-related distress and help-seeking behaviours, even if the symptoms fall below the established diagnostic threshold.

Anxiety and Depression

Prodrome in depression and anxiety is far less well-defined than in psychosis. We identified studies on prodrome in depression and anxiety using its broad definitions [16,17], also referred to as sub-threshold anxiety in anxiety disorders [18], and in the context of depressive symptoms comprising the prodrome of psychosis or bipolar disorder [19]. One review on prodrome in depression focused on early symptoms—cognitive, emotional, physical, and psychomotor—with 15 studies assessing prodrome retrospectively and 11 prospectively [7]. This highlighted the discrepancies and lack of agreement regarding the assessment of prodrome. There have been efforts to define CHR in depression [8] but these remain in the nascent stages. While these definitions may hold promise for early intervention in depression, this was not endorsed in our consultations; many considered that the risks of over-pathologisation of individuals exceeded its usefulness.

Areas of Agreement and Tensions in the Field

Agreements

- Early signs

An early stage that precedes the full onset of the psychiatric disorder, marked by subtle, emerging symptoms that indicate the potential for progression but are not yet severe enough to meet diagnostic criteria. This understanding is broadly accepted in psychosis but is much less structured in depression/ anxiety.

- Importance for early intervention

Identifying prodromal symptoms [CHR/UHR] at an early stage is essential, as this can help reduce severity of the disorder, delay progression, and improve treatment outcomes [20, 21].

- Use of at-risk concepts

Our formative work suggests that there is agreement across MHEs and LEEs that ‘prodrome’ is a retrospective and pessimistic concept which should be replaced with a prospective CHR concept.

Tensions

- Need for consensus

The term prodrome and the need for its standardised definition were highly debated. While there is growing support in the literature for a transdiagnostic prodrome or CHR that applies to multiple severe mental health problems [22], there were strong views within our consultations that the concept is not useful. This is due to difficulties in appropriately defining and measuring prodromal features across different conditions, and because many of the experts we consulted thought that the risk of stigmatising individuals as ‘at-risk’ (as few as 36% after 3 years will go on to develop the condition [23]) was more problematic than the possible advantages. However, these views may not be representative of PWLE: in one recent study MH professionals were much more likely to consider terms such as ARMS, UHR, or Attenuated Psychotic Symptoms as stigmatising (up to 70% thought this), compared to around 40% of PWLE who thought this [24].

- Western focused

Prodrome or CHR may be expressed differently across cultures, and many of the frameworks for identifying prodromal symptoms are based on Western diagnostic criteria, which may not apply universally. In many LICs, formal definitions and guidelines are absent. Additionally, certain symptoms might be interpreted in some societies as spiritual experiences or culturally sanctioned behaviours.

Conclusion

Is further consensus work needed?

No, we do not recommend further consensus building on defining prodrome.

The concept of prodrome, historically used to describe early signs preceding psychiatric disorders, is broadly critiqued for its retrospective nature and lack of clear boundaries. It is now largely replaced by CHR, particularly in psychosis, which has greater predictive utility and standardised criteria.

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9.13 Resilience

Resilience has received significant academic interest over the last fifty years [1–4]. Psychological perspectives on resilience focus on the ability of individuals to grow, develop, and learn in the light of traumas, adversity, or challenges [5]. Our MH and LE experts consistently highlighted the importance of resilience in the landscape of early interventions.

Table 9.13 Characteristics of the papers reviewed [45]

Publication Year	No. papers	Region	No. papers
2015-2025	17 (47.2%)	Americas	20 (55.6%)
2004-2014	13 (36.1%)	Europe	9 (25.0%)
1994-2003	6 (16.7%)	Western Pacific	5 (13.9%)
Before 1994	0 (0.0%)	Africa	0 (0.0%)
		Southeast Asia	2 (5.6%)
		Eastern Mediterranean	0 (0.0%)
Totals	**36**		**36**

Consensus Landscape

There is no universal definition of resilience in the empirical literature published this century [1]. A recent attempt to develop consensus on the definition of resilience in children revealed complex challenges [6]. While it was agreed that resilience involves multiple interacting factors, there was no consensus on whether resilience is a trait or an outcome; the strongest agreement was that resilience encompasses rebounding from serious stressors.

Definitions of resilience

The debates around resilience largely revolve around ambiguities in its definition and challenges in its operationalisation [7]. While this is the case with many terms examined in this project, something unique to resilience is that most measures only include positive items, and most definitions only speak to positive adaptation/dealing with distress. However, resilience may also be maladaptive (e.g. developing unrealistic goals, over-tolerance of adversity). While there is broad agreement that resilience is shaped by various factors at different levels [8], its conceptualisation is debated. Resilience has been defined as a capacity, a process, an outcome, and a trait (despite evidence challenging the trait-based perspective) [9]. Recent reviews highlight diverse definitions [1,10], including:

- a process of overcoming adversity.
- an ability to recover quickly.
- sustaining well-being despite adversity.
- good mental health.
- bouncing back.
- adapting.
- ordinary magic—a fundamental human attribute rooted in relationships and social connections.
- absence of mental health problems following adversity.
- ability to functionally adapt and thrive in response to stressors.
- returning to baseline after adversity.
- harnessing internal and external resources.
- dynamic, system-level process.

45 Table 9.13 indicates the number of academic published papers reviewed on resilience and their characteristics. Region refers to either the region where the study was conducted or the regional affiliation of the first author.

Anderson and colleagues' framework [11] synthesises some of these differences to help describe, categorise, and compare different concepts. First, resilience can mean overcoming distress and returning to baseline (or even achieving higher functioning), or withstanding adversity without experiencing distress; the former is more common in resilience research than the latter. Second, resilience can be a stable trait, an inherent quality that shapes responses to adversity, or a dynamic process that evolves over time. The latter is difficult to measure through the use of a standardised tools at a single time point, which many researchers commonly do. Lastly, resilience can be examined at the individual level or at the group level, which speaks to collective action in response to adversity.

Areas of Agreement and Tensions in the Field

Agreements

- Resilience reflects the ability of an individual or a community to navigate and recover from adversity.
- Adversity is implied in all definitions.

Tensions

- The nature of resilience

Is the commonly used notion of bouncing back always helpful? What if individuals bounce back to a place that was harmful, particularly for those living in persistent adversity? [12]; however, some mental health experts state that this conceptualisation can still be helpful, because the comparison is with oneself and not others similar to you.

- Can resilience be negative?

Resilience is usually viewed as a positive, but qualitative research involving PWLE [13] on threats such as climate change [14] (defining it as transilience[46] as opposed to resilience), and numerous commentaries, posit that resilience can be both negative and positive [15–17]. This is partially because if the adversity being dealt with is structural in origin, then resilience can be seen as an unhelpful adaptation to systemic oppression, a position taken by many LEEs in our consultations. Further, as reported by lived and mental health experts in our consultations, resilience can pathologise individuals who are not resilient.

- Individual versus societal

Resilience is often viewed as an individual attribute—but research and experts suggest that resilience may be a result of the social and political environments that make it possible for people to be resilient, or not — these are often overlooked in current definitions and research [12]. Further, lived and mental health experts in our consultations described how underserved communities are repeatedly denied resources, and therefore their resilience is dependent on external factors that may not always be clear. Hence, as noted by participants in our consultations, the concept of 'bouncing back' places responsibility on individuals, yet there are often systemic issues underpinning people's ability to be resilient.

- Resilient or not resilient

Resilience is sometimes conceptualised as a binary (resilient or not), which will often be simplistic, as resilience can change based on contexts [18].

46 Transilience: Nasi and colleagues describe this as 'doing more than just bouncing back'. It is people's perceived capacity to persist (persistence), adapt flexibly (adaptability), and positively transform (transformability) in the face of climate change risks.

Other areas where the nature of resilience is unclear include:

- Vagueness of definitions: how quickly can one be expected to recover if resilience is 'the ability to recover quickly', and for how long must this persist?

- Clarity of over the comparators: sometimes it is the self, sometimes it is others with similar socio-demographic variables.

Finally, definitional variation leads to proliferation of measures. Commonly used self-report measures of resilience can be inadequate because individuals cannot always appraise their ability to navigate adversity, especially when completing such measures when adversity is not present.

- Is it possible to build consensus?

A common view stated both within the research reviewed and from many of our participants was that a clear definition of resilience is needed to improve early interventions and hypothesis testing. One such notable attempt by the NIH to strengthen strategic priorities related to resilience [19]. On the other hand, many experts held the view that a universal definition of resilience may neither be possible nor desirable, due to its inherent diversity, arguing that debate over the correct concept is unlikely to lead to consensus. The weight of evidence suggests that research on resilience should shift from examining it as a fixed individual-trait perspective to one where it is viewed as dynamic, fluid, mutable. Experts in our consultations also corroborated that operationalising and consensus building is not as useful as it could be in defining resilience circumstantially and environmentally; but they also agreed that transparency in definition and measurement is still essential.

Conclusion

Is further consensus needed?

No, we do not recommend further consensus building on defining the term resilience.

Resilience is highly subjective and varies across cultures and contexts. An attempt at a single definition risks oversimplifying its dynamic nature making universal agreement both unlikely and, perhaps, unhelpful. This is also highlighted in expert consultations where many advocated against a reductionist approach to resilience.

However, transparency in the way studies report and define what they mean by resilience in the context of their study, as well as specifying the type of resilience being investigated (e.g. self-reported psychological resilience or observed resilience to genetic risk) [20] may improve researchers' ability to appraise approaches.

> "We tell people that adversity builds resilience. But when does it stop? At what point does someone get to say, 'I've had enough adversity'?"
> *-- Lived experience expert, interview*

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9.14 Trauma and Trauma-Informed Care

Psychiatry has historically considered psychological trauma[47] within its understanding of post-traumatic stress disorder (PTSD); trauma is an event leading to a condition. DSM-III describes it as an event *"outside the range of usual human experience"* causing fear or helplessness [1] ; ICD-10 defines it as *"exceptionally threatening or catastrophic"* [2] ; DSM-IV introduced specific events like *"actual or threatened death, serious injury, or threats to physical integrity"*, requiring an emotional response [3]; DSM-5 removed the emotional response criterion, narrowing trauma to something causing *"actual or threatened death, serious injury, or sexual violence"* [4], a framing also used in ICD-11 [5]. Workshop discussions highlighted concerns that event-based definitions overlook the emotional and cultural aspects of trauma. Participants emphasised that definitions should incorporate both the objective characteristics of an event and the subjective experience of the individual, as trauma is not perceived the same way across populations and cultures.

Another way to address this term relates to its use beyond PTSD, describing both the causative events and their lasting physical and psychological effects, but unrelated to any diagnosis of PTSD [6]. Trauma-informed care (TIC) emphasises the recognition of trauma's impact and the fostering of healing environments.

Table 9.14 Characteristics of the papers reviewed [48]

Publication Year	No. papers	Region	No. papers
2015-2025	35 (85.4%)	Americas	30 (73.2%)
2004-2014	5 (12.2%)	Europe	7 (17.1%)
1994-2003	1 (2.4%)	Western Pacific	3 (7.3%)
Before 1994	0 (0.0%)	Africa	0 (0.0%)
		Southeast Asia	0 (0.0%)
		Eastern Mediterranean	1 (2.4%)
Totals	**41**		**41**

Consensus Landscape

Trauma

There is no universally accepted definition of psychological trauma. One of the most commonly referenced definitions (cited more than 617 times) is from SAMHSA[49] which describes trauma as resulting from harmful or life-threatening events that have lasting negative effects on well-being [7]. Other definitions frame (psychological) trauma as an emotional response to an extremely negative situation [8], a breaking point [9], or any event with lasting psychological impact [10]. Beyond individual trauma, the concept extends to collective trauma affecting entire societies [11], racial trauma linked to discrimination [12], and cultural trauma shaped by genocide, hate crimes, and colonisation [13]. Trauma is also used colloquially to describe everyday difficulties; one such example being losing your luggage [14].

47 As distinguished from 'physical trauma' as used in medicine: a bodily injury resulting from an external force, which might involve damage to tissues, organs, or bones caused by mechanical, thermal, electrical, chemical, or radiological energy.
48 Table 9.14 indicates the number of academic published papers reviewed on trauma and trauma-informed care and their characteristics. Region refers to either the region(s) where the study was conducted or the regional affiliation of the first author.
49 Substance Abuse and Mental Health Services Administration. For the full list of abbreviations, refer to section 1.

The concept has expanded significantly, with 23 variations identified, including vicarious, social, and historical trauma [15]. Some researchers warn of conceptual bracket creep, arguing that expanding definitions risks conflating severe trauma with general distress, thus reducing clinical precision and diverting resources [16]. Our consultations revealed that the broadening of trauma's definition contributed to its frequent misuse in popular discourse.

The distinction between trauma and adversity is also debated, with some viewing adversity as common and necessary for growth [17], a perspective echoed in our consultations[50]. Examples of adversity include academic failure, job loss, or social rejection—challenging but not necessarily traumatic. However, some adversities such as childhood abuse or neglect fall under Adverse Childhood Experiences (ACEs), which are linked to long-term psychological harm. For example, a recent meta-analysis extracted data from 183 studies comprising 349,265 individuals to examine the relationship between childhood adversity and psychosis, finding significant associations, and that psychosis onset was earlier in individuals exposed to adversity [18]. While ACEs are categorised as adversities, not all fit the framing of adversity as a growth experience, highlighting an important conceptual overlap [19, 20].

Trauma definitions remain inconsistent in research. Reviews classify trauma variably, e.g., as interpersonal violence and betrayal, cancer diagnoses, and assault [19, 21]. Meanwhile, measurement tools have proliferated, with 363 trauma-related measures identified, yet psychometric inconsistencies hinder comparability [22] and cultural nuances are overlooked, making it difficult to assess trauma experiences in non-Western contexts.

Trauma-informed care (TIC)

Rather than a single definition, the literature identifies core principles that underpin TIC [23, 24]. Frameworks highlight key elements such as staff training, safety, empathy, peer support, and cultural awareness [3, 25–26]. Workshop participants agreed with this principle-based approach, although some were concerned about TIC becoming a superficial label rather than a meaningful practice.

Although numerous system-level components have been identified, including interagency collaboration and leadership, these are inconsistently applied [27]. A total of 15 components of TIC have been implemented across workforce development, trauma-focused services, and organisational change [28], while 28 separate components were identified in trauma-informed schools [29]. TIC is widely associated with the principle that all care should assume a history of trauma, with systems prioritising safety, choice, and control [15, 30, 31].

The absence of a standardised definition creates challenges in both applying and evaluating trauma-informed approaches in practice [32]. Our qualitative findings indicate that TIC is widely referenced but its operationalisation varies significantly across contexts.

50 Some participants argued that while adversity can contribute to personal growth, trauma is distinct in its long-term psychological impact and should not be equated with everyday challenges.

Areas of Agreement and Tensions in the Field

Agreements

- Trauma

Trauma lacks a single definition outside PTSD classification, but the SAMHSA model is widely referenced. Workshop participants agreed that trauma should consider the individual's perception of the event. There was also agreement that trauma definitions should account for cultural and systemic factors.

- TIC

TIC is essential in healthcare, social services, and education. TIC should be non-coercive, culturally responsive, and centred on safety, trust, and empowerment. Participants broadly supported defining core TIC principles—peer support, collaboration, and transparency—to ensure consistency. TIC should remain flexible and adaptable, rather than being reduced to a rigid checklist.

Tensions

- Broad versus narrow conceptualisation

Whether trauma should be broadly defined as any event with lasting negative effects or restricted to specific, severe events is debatable. Narrow definitions may exclude experiences like racial discrimination [33], while overly broad definitions risk diluting the term's meaning [34]. Some suggest that the emotional response criterion should be re-introduced, while others question whether trauma needs a definition at all [35]. Our participants supported a balanced approach; trauma should be defined in ways that acknowledge both its psychological and systemic dimensions.

- Trauma versus adversity

The distinction between trauma and adversity is unclear. The ACE perspective [36] has influenced research and practice; however, some argue that adversity is an experience, while trauma is its psychological impact [37].

- Too many measures

A recent review identified 363 unique measures of trauma, but they were deemed confusing, redundant, and variable [38].

Conclusion

Is further consensus needed – Trauma?

No, we do not recommend further consensus building for the definition of trauma.

The use of the term in relation to other areas of mental health is so broad that attempting to reach a singular definition would be impractical, but achieving greater alignment on TIC principles could improve consistency and effectiveness in service delivery, with tailored approaches across settings [35].

Is further consensus work needed – TIC?

Yes, we do recommend further consensus building for the definition of TIC.

Alignment on safety, cultural responsiveness, and system-wide implementation would enhance clarity in research and practice; agreement on defining and measuring TIC would strengthen its effectiveness and ensure that it can be meaningfully integrated.

One person's adversity is another person's trauma. And one person's trauma is another person's ordinary experience"

– Lived experience expert, interview

References for Trauma and Trauma-Informed Care

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10.

Conclusions

Conclusions

Our landscaping has highlighted wide variation in the definitions of key mental health terms. In some cases, such as with the term mechanism, the variation in terms is helpful as it is appropriate that researchers from different fields use the same term to mean different things; and it also allows for conceptual innovation and integration of diverse stakeholder perspectives.

However, examining these variations has also presented an opportunity to demonstrate that greater alignment can be helpful in both research and practice.

In many instances, standardising the definitions of terms will enhance comparability across studies, improve evidence synthesis, and ensure that research findings are applicable to clinical care. However, achieving consensus requires a balance between scientific precision and contextual flexibility in order to ensure that definitions are relevant across diverse populations and healthcare systems, and relevant to those with lived experience of mental health disorders.

Moving forward, collaborative engagement is critical. Researchers, clinicians, policymakers, and individuals with lived experience must work together to create inclusive, culturally attuned, and methodologically meaningful definitions. Our project critically highlights the importance of regional inclusivity, particularly in low-and-middle income countries, where definitions may not fully reflect the lived realities of people with mental health conditions or the local mental health systems.

> Some definitions exist because they are easier to measure. But is that the right way to define them? Who benefits from those definitions—patients, or the system?"
> *—Mental health expert, workshop consultation*

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12. Appendices

Wellcome supports science to solve the urgent health challenges facing everyone. We support discovery research into life, health and wellbeing, and we're taking on three worldwide health challenges: mental health, infectious disease, and climate and health.

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