World Health Organization

mhGAP

Mental Health Gap Action Programme (mhGAP) guideline for mental, neurological and substance use disorders

Executive summary

Suggested citation. Mental Health Gap Action Programme (mhGAP) guideline for mental, neurological and substance use disorders: executive summary. Geneva: World Health Organization; 2025. https://doi.org/10.2471/B09329

Executive summary

Background and objectives

Mental, neurological and substance use (MNS) disorders are major contributors to morbidity and premature mortality in all regions of the world. The resources that have been provided to tackle the huge burden of MNS disorders are insufficient, inequitably distributed and inefficiently used, resulting in a large treatment gap. To reduce the treatment gap and to enhance the capacity of countries to respond to the growing challenge, the World Health Organization (WHO) developed and launched (in 2008) the Mental Health Gap Action Programme (mhGAP): scaling up care for MNS disorders. An essential component of mhGAP is the evidence-based guideline for MNS disorders identified as conditions of high priority for low- and middle-income countries (LMICs). These recommendations were first published in 2010 as part of the mhGAP intervention guide, and they were updated in the 2015 mhGAP guideline. There has been a rapid expansion in the use of mhGAP since 2015 with the guideline and derivate products – especially the 2016 intervention guide – now used in more than 100 countries and translated into more than 20 languages.

The mhGAP guideline update aims to:

- provide up-to-date WHO guidance to facilitate delivery of MNS interventions by non-specialist health workers in LMICs;
- assist with the scale-up of care for MNS disorders identified as conditions of high priority in LMICs; and
- facilitate implementation of WHO action plans including the *Comprehensive mental health action plan 2021–2030,* the *Intersectoral global action plan on epilepsy and other neurological disorders 2022–2031,* the *Global action plan on the public health response to dementia 2017–2025,* and the *Global alcohol action plan 2022–2030* by health-care planners and programme managers in LMICs.

Target audience

The guideline is targeted towards non-specialized health workers at primary- or secondary-level health-care facilities, or those working at the district level including basic inpatient and outpatient services. The guideline also targets health workers in general health care and other programmes to support delivery of integrated care and services. The guideline is relevant to other health-care professionals globally, including staff at ministries of health, nongovernmental organizations (NGOs) and researchers at academic institutions, especially in LMICs, and it is also intended for use by health-care planners, programme managers and policy-makers.

Methods

The guideline was developed in accordance with the *WHO handbook for guideline development* and meets international standards for evidence-based guidelines. In collaboration with the Guideline Development Group (GDG), the Topic Expert Groups (TEGs) and the guideline methodologist, the WHO Steering Group identified priority questions and outcomes to determine those that were critical for the update of the guideline. Conflicts of interest from all individual guideline contributors were declared, assessed and managed in line with WHO procedures. Systematic evidence reviews were used to develop the Evidence to Decision and Summary of Findings tables, according to the Grading of Recommendations Assessment, Development and Evaluations (GRADE) approach. The GDG developed recommendations that considered a range of elements, namely: the certainty of the evidence; the balance between desirable and undesirable effects; values and preferences of intended users of the intervention; resource requirements and cost-effectiveness; health equity, equality and non-discrimination; feasibility; human rights and sociocultural acceptability.

When making a strong recommendation, the GDG was confident that the desirable effects of the intervention outweighed any undesirable effects. When the GDG was uncertain about the balance between the desirable and undesirable effects, the GDG issued a conditional recommendation. **Strong recommendations** imply that most individuals would want the intervention and should receive it, while **conditional recommendations** imply that different choices may be appropriate for different individuals, and they may require assistance to work towards a decision. The GDG members reached a unanimous agreement on all the recommendations and ratings in this guideline.

Summary of recommendations

This guideline includes 48 updated and new evidence-based recommendations related to MNS conditions. These are based on 30 updated PICO (population, intervention, comparator, outcome) questions that were included in the previous mhGAP guideline (2015), and 18 new PICO questions developed for this new edition of the guideline. For one other updated PICO question the evidence was insufficient to support an updated recommendation so the pre-existing recommendation continues to be endorsed; also for one other new PICO question there was insufficient evidence to support a new recommendation. The updated and new recommendations stand alongside 90 pre-existing guideline recommendations which were validated and continue to be endorsed in their current format.

The 48 updated and new recommendations and the 2 for which evidence was insufficient to support an updated or new recommendation are presented in Table 1, arranged among 11 modules: alcohol use disorders (ALC), anxiety (ANX), child and adolescent mental disorders (CAMH), conditions related to stress (STR), dementia (DEM), depression (DEP), drug use disorders (DRU), epilepsy and seizures (EPI), overarching areas (OVE), psychosis and bipolar disorder (PSY) and self-harm and suicide (SUI).

TABLE 1. Summary of recommendations

Module and recommendation number	Recommendation Strength of the recommendation and certainty of the evidence
Alcohol use disorders (ALC)	
ALC1 (update)	**Baclofen should be considered for treatment of adults with alcohol dependence post-detoxification.** Conditional recommendation. Moderate certainty of evidence.
ALC2 (update)	**Structured and standardized psychosocial interventions should be considered for the treatment of alcohol dependence.** Conditional recommendation. Low certainty of evidence.
ALC3 (new)	**Digitally delivered interventions should be considered for adults with alcohol use disorders or with hazardous alcohol use. They should not replace provision of other forms of interventions and should ensure free and informed consent, safety, confidentiality, privacy and security.** Conditional recommendation. Low certainty of evidence.

TABLE 1. Summary of recommendations

Module and recommendation number	Recommendation Strength of the recommendation and certainty of the evidence
ALC4 (new)	**Combined psychosocial and pharmacological interventions should be offered for adults with alcohol dependence.** Strong recommendation. Moderate certainty of evidence.
Anxiety (ANX)	
ANX1 (new)	**Selective serotonin reuptake inhibitors (SSRIs) should be considered for adults with panic disorder. If SSRIs are not available, consider offering tricyclic antidepressants (TCAs). SSRIs should be considered for adults with generalized anxiety disorder (GAD).** Conditional recommendation. Low certainty of evidence.
ANX2 (new)	**Brief, structured psychological interventions based on principles of cognitive behavioural therapy (CBT) should be offered for adults with generalized anxiety disorder (GAD) and/or panic disorder.** Strong recommendation. Moderate certainty of evidence.
ANX3 (new)	**When brief, structured psychological interventions based on principles of cognitive behavioural therapy (CBT) are offered for adults with generalized anxiety disorder (GAD) and/or panic disorder, different delivery formats should be considered based on available resources as well as individual preferences, including:** • **individual and/or group face-to-face;** • **digital/online and/or face-to-face;** • **guided and/or unguided self-help;** • **specialist and/or non-specialist.** Conditional recommendation. Low certainty of evidence.
ANX4 (new)	**Stress management techniques, namely relaxation and/or mindfulness training, should be considered for adults with generalized anxiety disorder (GAD) and/or panic disorder.** Conditional recommendation. Low certainty of evidence.
ANX5 (new)	**Structured physical exercise should be considered for adults with generalized anxiety disorder (GAD) and/or panic disorder.** Conditional recommendation. Very low certainty of evidence.
ANX6 (new)	**Benzodiazepines are not recommended for the treatment of adults with generalized anxiety disorder (GAD) and/or panic disorder. For emergency management of acute and severe anxiety symptoms, benzodiazepines may be considered, but only as a short-term (3–7 days maximum) measure.** Strong recommendation. Low certainty of evidence.
ANX7 (new)	**Collaborative care should be considered for adults with depression and/or anxiety and physical health conditions.** Conditional recommendation. Low certainty of evidence.

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Module and recommendation number	Recommendation Strength of the recommendation and certainty of the evidence
Child and adolescent mental disorders (CAMH)	
CAMH1 (update)	**For children 6 years old and above and adolescents who have an attention deficit hyperactivity disorder (ADHD) diagnosis, methylphenidate may be considered, provided that:** • **ADHD symptoms are still causing persistent significant impairment in at least one domain of functioning (education, interpersonal relationships, occupation), after the implementation of environmental modifications in schools, at home or in other relevant settings;** • **a careful assessment of the child/adolescent has been conducted;** • **the child/adolescent and the caregivers, as appropriate, have been informed about ADHD treatment options and supported in decision-making;** • **methylphenidate prescription is made by, or in consultation with, a specialist.** Conditional recommendation. Low certainty of evidence.
CAMH2 (new)	**2.1 Universally delivered psychosocial interventions that use curriculum-based, family-based, exercise-based methods and/or social and personal skills development to improve emotional regulation should be considered for promotion of psychosocial well-being in children.** Conditional recommendation. Very low certainty of evidence.
	2.2 Psychosocial interventions that include cognitive behavioural therapy (CBT), psychoeducation and family-focused treatment approaches should be offered to children whose parents have mental health conditions for the prevention of depression and anxiety. Strong recommendation. Low certainty of evidence.
CAMH3 (new)	**3.1 Psychosocial interventions focused on social skills training and developmental behavioural approaches should be offered to improve development, well-being and functioning in children and adolescents with autism.** Strong recommendation. Low certainty of evidence.
	3.2 Cognitive behavioural therapy (CBT) should be offered to children and adolescents with autism with anxiety. Strong recommendation. Moderate certainty of evidence.
	3.3 Psychosocial interventions focused on social skills, cognitive and organizational skills training should be considered to improve development and functioning in children and adolescents with attention deficit hyperactivity disorder (ADHD). Conditional (social skills training, cognitive interventions) and Strong (organizational skills training) recommendation. Moderate certainty of evidence.

TABLE 1. Summary of recommendations

Module and recommendation number	Recommendation Strength of the recommendation and certainty of the evidence
CAMH3 (new) (continued)	**3.4 Beginning-to-read interventions should be offered to improve communication and academic performance in children with disorders of intellectual development.** Strong recommendation. Moderate certainty of evidence.
	3.5 Early communication interventions involving direct instruction approaches should be considered for improving expressive phonological skills and reducing stuttering for children with developmental speech disorders. Conditional recommendation. Very low certainty of evidence.
	3.6 Psychosocial interventions using cognitive learning techniques to enhance communication and social competencies should be considered for children and adolescents with neurodevelopmental disabilities. Conditional recommendation. Low certainty of evidence.
	3.7 Structured physical exercise should be considered to improve development, including social and communication development, and functioning in children and adolescents with autism. Conditional recommendation. Low certainty of evidence.
	3.8 Structured physical exercise should be considered to improve motor skills and functioning, including attention and executive functioning, and reduce anxiety and problem behaviours in children and adolescents with attention deficit hyperactivity disorder (ADHD). Conditional recommendation. Very low certainty of evidence.
	3.9 Specialized instructional techniques should be considered to improve academic performance, including writing skills, reading comprehension and maths, in children and adolescents with developmental learning disorders. Conditional recommendation. Very low certainty of evidence.
	3.10 Task-oriented instruction should be considered to improve motor skills and task performance in children with developmental coordination disorders. Conditional recommendation. Very low certainty of evidence.
	3.11 Structured physical exercise and activity should be offered to improve development outcomes, including motor skills and functioning, in children and adolescents with cerebral palsy. Strong recommendation. Low certainty of evidence.

TABLE 1. Summary of recommendations

Module and recommendation number	Recommendation Strength of the recommendation and certainty of the evidence
CAMH4 (new)	**4.1 Pharmacological interventions are not recommended in children and adolescents with anxiety disorders.** Strong recommendation. Low certainty of evidence.
	4.2 Antidepressant medicines are not recommended for the treatment of children 12 years of age and below with depressive episode/disorder. Strong recommendation. Low certainty of evidence.
	4.3 If psychosocial interventions alone prove ineffective in adolescents (13–17 years) with moderate-to-severe depression, referral to or consultation with a specialist should be offered, to undertake a more comprehensive assessment and to explore initiation of fluoxetine in combination with psychological treatments. Strong recommendation. Low certainty of evidence.
Conditions related to stress (STR)	
STR1 (update)	**Psychological interventions should be considered for adults with post-traumatic stress disorder (PTSD). Namely, these include:** • **individual face-to-face cognitive behavioural therapy (CBT) with a trauma focus;** • **group face-to-face CBT with a trauma focus;** • **digital/remote CBT with a trauma focus;** • **eye movement desensitization and reprocessing (EMDR);** • **stress management.** Conditional recommendation. Low certainty of evidence.
STR2 (update)	**Psychological interventions should be offered for children and adolescents with post-traumatic stress disorder (PTSD). Namely, these include:** • **individual face-to-face cognitive behavioural therapy (CBT) with a trauma focus;** • **group face-to-face CBT with a trauma focus;** • **eye movement desensitization and reprocessing (EMDR).** Strong recommendation. Moderate certainty of evidence.
Dementia (DEM)	
DEM1 (update)	**1.1 Psychosocial interventions – namely mindfulness-based interventions, multicomponent interventions, psychoeducation and psychotherapy/counselling – should be offered for carers of people living with dementia.** Strong recommendation. Low certainty of evidence.
	1.2 Respite care should be considered for carers of people living with dementia. Conditional recommendation. Low certainty of evidence.

TABLE 1. Summary of recommendations

Module and recommendation number	Recommendation Strength of the recommendation and certainty of the evidence
DEM1 (update) (continued)	**1.3 Depression and anxiety in carers of people living with dementia should be assessed and treated in line with mhGAP recommendations for depression and anxiety.** Strong recommendation. Low certainty of evidence.
DEM2	There was insufficient evidence to update the recommendation, so the existing recommendation remains valid. **Psychological interventions – namely cognitive behavioural therapy (CBT), interpersonal therapy (IPT), structured counselling and behavioural activation therapy (BAT) – should be considered for people living with dementia and mild-to-moderate depression.** Conditional recommendation. Low certainty of evidence.
DEM3 (update)	**3.1 Physical activity interventions – namely physical exercise delivered 3–4 times per week for 30–45 minutes for more than 12 weeks – should be offered to people living with dementia.** Strong recommendation. High certainty of evidence.
	3.2 Non-pharmacological interventions – namely CBT, cognitive stimulation therapy and cognitive training (in alphabetical order) – should be considered for people living with dementia. Conditional recommendation. Low certainty of evidence.
Depression (DEP)	
DEP1 (update)	**In adults with moderate-to-severe depression, citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine or sertraline (SSRIs) or amitriptyline (TCA) should be considered.** Conditional recommendation. Very low certainty of evidence.
DEP2 (update)	**In adults with moderate-to-severe depression who have benefited from initial antidepressant treatment, continuation of the antidepressant treatment should be considered for at least six months after remission. Treatment should be regularly monitored, with special attention to treatment adherence, change in depressive symptoms and possible adverse effects.** Conditional recommendation. Very low certainty of evidence.
DEP3 (update)	**Structured psychological interventions should be offered for the treatment of adults with moderate-to-severe depression, namely behavioural activation therapy (BAT), brief psychodynamic therapy, cognitive behavioural therapy (CBT), interpersonal therapy (IPT), problem-solving therapy (PST) and third wave therapies (3WV).** Strong recommendation. Moderate certainty of evidence.

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Module and recommendation number	Recommendation Strength of the recommendation and certainty of the evidence
DEP4 (update)	**In adults with moderate-to-severe depression, psychological interventions or combined treatment should be considered based on individual preferences and careful consideration of the balance of benefits and harms. Antidepressant medicine alone for adults with depression (moderate to severe) should only be considered when psychological interventions are not available. Providers should keep in mind the possible adverse effects associated with antidepressant medicines, and individual preferences.** Conditional recommendation. Low certainty of evidence.
Drug use disorders (DRU)	
DRU1 (update)	**1.1 Adults using cannabis should be offered screening and brief intervention. Brief intervention should comprise at least a single session, incorporating individualized feedback and advice on reducing or stopping cannabis consumption, and the offer of follow-up care.** Strong recommendation. Very low certainty of evidence.
	1.2 Adults using psychostimulants should be offered screening and brief intervention. Brief intervention should comprise at least a single session, incorporating individualized feedback and advice on reducing or stopping psychostimulant consumption, and the offer of follow-up care. Strong recommendation. Very low certainty of evidence.
	1.3 For adults with hazardous cannabis or psychostimulant use, or with disorders due to use of these substances who do not respond to brief interventions, referral for specialist intervention should be considered. Conditional recommendation. Very low certainty of evidence.
DRU2 (update)	**Dexamphetamine, methylphenidate and modafinil are not recommended for the treatment of cocaine or stimulant use disorders due to safety concerns.** Conditional recommendation. Low certainty of evidence.
DRU3 (update)	**Psychosocial interventions – namely cognitive behavioural therapy (CBT) and contingency management – should be offered to adults with cocaine and stimulant dependence.** Strong recommendation. Low certainty of evidence.
DRU4 (new)	**Digital interventions should be considered for adults using drugs or with drug use disorders. They should not replace provision of other forms of interventions and should ensure informed consent, safety, confidentiality, privacy and security.** Conditional recommendation. Very low certainty of evidence.

TABLE 1. Summary of recommendations

Module and recommendation number	Recommendation Strength of the recommendation and certainty of the evidence
DRU5 (new)	**Recovery-oriented services on a voluntary basis should be considered for adults with drug dependence. Namely, case management, long-term residential and continuing community care approaches, occupation-based therapies and peer support groups should be considered for recovery management of people with drug dependence.** Conditional recommendation. Low certainty of evidence.
Epilepsy and seizures (EPI)	
EPI1 (update)	**In adults with established status epilepticus, i.e. seizures persisting after two doses of benzodiazepines, either intravenous fosphenytoin, intravenous phenytoin, intravenous levetiracetam, intravenous phenobarbital or intravenous valproic acid (sodium valproate) should be considered with appropriate monitoring. The choice of these medicines depends on local resources, including availability and facilities for monitoring.** Conditional recommendation. Low certainty of evidence.
EPI2 (update)	**In children with established status epilepticus, i.e. seizures persisting after two doses of benzodiazepines, intravenous fosphenytoin, intravenous phenytoin, intravenous levetiracetam, intravenous phenobarbital or intravenous valproic acid (sodium valproate) should be considered with appropriate monitoring. The choice of these medicines depends on local resources, including availability and facilities for monitoring.** Conditional recommendation. Moderate certainty of evidence.
EPI3 (update)	**3.1 Generalized onset seizures:** **Monotherapy with lamotrigine or levetiracetam, or valproic acid (sodium valproate), should be offered as first-line treatment for generalized onset seizures in men/boys and women/girls who are not of childbearing potential.** **In women and girls of childbearing potential with generalized onset seizures, lamotrigine or levetiracetam should be offered as first-line monotherapy.** **If the first monotherapy is not successful for generalized onset seizures, an alternative first-line monotherapy should be tried.** **Valproic acid (sodium valproate) is not recommended in women and girls of childbearing potential owing to the high risk of birth defects and neurodevelopmental disorders in children exposed to valproic acid (sodium valproate) in the womb.** **If lamotrigine, levetiracetam and valproic acid (sodium valproate) are not available for generalized onset seizures, monotherapy with either phenytoin or phenobarbital can be considered.** Strong recommendation. High certainty of evidence.

TABLE 1. Summary of recommendations

Module and recommendation number	Recommendation Strength of the recommendation and certainty of the evidence
EPI3 (update) (continued)	**3.2 Focal onset seizures:** **Monotherapy with lamotrigine or levetiracetam should be offered as first-line treatment for focal onset seizures in children and adults with epilepsy.** **If neither lamotrigine nor levetiracetam are available, then carbamazepine should be used as an alternate first-line treatment for focal onset seizures in children and adults with epilepsy.** **If the first monotherapy is not successful for focal onset seizures, an alternative first-line monotherapy should be tried.** **Lacosamide should be offered as a second-line monotherapy for focal onset seizures if none of the first-line medicines are effective.** **If antiseizure medicine monotherapy is unsuccessful in people with generalized onset seizures or focal onset seizures, prompt referral should be made to a specialist for consideration of other treatment options.** Strong recommendation. High certainty of evidence.
EPI4 (update)	**4.1** The efficacy of antiseizure medicines (ASMs) is not thought to differ in males and females. As such, this recommendation builds on EPI3 and focuses on the medicines that are now being preferentially recommended as therapeutic options. **In women and girls with epilepsy who are of childbearing potential, lamotrigine or levetiracetam should be offered as first-line monotherapy for both generalized onset seizures and focal onset seizures.** **Women with epilepsy should have seizures controlled as well as possible with the minimum dose of ASMs taken in monotherapy, wherever possible.** **Valproic acid (sodium valproate) is not recommended in women and girls of childbearing potential because of potential harm to the fetus.** Strong recommendation. Very low certainty of evidence.
	4.2 Standard breastfeeding recommendations remain appropriate for women with epilepsy taking the ASMs included in this review (phenobarbital, phenytoin, valproic acid [sodium valproate], carbamazepine, lamotrigine, levetiracetam, topiramate, lacosamide). Strong recommendation. Very low certainty of evidence.
EPI5 (new)	**Nocturnal supervision should be considered for prevention of sudden unexpected death in epilepsy (SUDEP).** Conditional recommendation. Very low certainty of evidence.

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Module and recommendation number	Recommendation Strength of the recommendation and certainty of the evidence
Overarching areas (OVE)	
OVE1 (new)	**Psychosocial interventions – namely psychoeducation using problem-solving and cognitive-behavioural approaches (either individual or family-based), self-help interventions and mutual support groups – should be considered for carers of persons with psychosis or bipolar disorder.** Conditional recommendation. Moderate certainty (carers of persons with psychosis or bipolar disorder), very low certainty (carers of persons with substance use disorder) of evidence.
Psychosis and bipolar disorder (PSY)	
PSY1 (update)	**1.1 Oral antipsychotic medicines – namely aripiprazole, chlorpromazine, haloperidol, olanzapine, paliperidone, quetiapine, risperidone – should be offered for adults with a psychotic disorder (including schizophrenia), carefully balancing effectiveness, side-effects and individual preference.** Strong recommendation. Moderate certainty of evidence.
	1.2 Clozapine should be considered for adults with a treatment-resistant psychotic disorder (including schizophrenia) under mental health specialist supervision, carefully balancing effectiveness, side-effects and individual preference. Conditional recommendation. Moderate certainty of evidence.
PSY2 (update)	**Maintenance therapy with antipsychotic medicine for a minimum of 7–12 months should be offered in adults with a first episode of psychosis (including schizophrenia) in remission, carefully balancing effectiveness, side-effects and individual preference.** Strong recommendation. Moderate certainty of evidence.
PSY3 (update)	**Maintenance therapy with mood stabilizers or antipsychotic medicines should be considered for at least six months for adults with bipolar disorder in remission, carefully balancing effectiveness, side-effects and individual preference.** Conditional recommendation. Low certainty of evidence.
PSY4 (update)	**Long-acting injection (LAI) antipsychotic medicines – namely fluphenazine, haloperidol, paliperidone, risperidone and zuclopenthixol – should be considered as an alternative to oral antipsychotic medicines for adults with psychotic disorders (including schizophrenia) requiring long-term treatment, carefully balancing effectiveness, side-effects and individual preference.** Conditional recommendation. Moderate certainty of evidence.

TABLE 1. Summary of recommendations

Module and recommendation number	Recommendation Strength of the recommendation and certainty of the evidence
PSY5 (update)	**5.1 Oral antipsychotic medicines – namely aripiprazole, olanzapine, paliperidone, quetiapine, risperidone – should be considered under specialist supervision for adolescents with psychotic disorders (including schizophrenia), carefully balancing effectiveness, side-effects and individual preference.** Conditional recommendation. Low certainty of evidence.
	5.2 Clozapine should be considered for adolescents with a treatment-resistant psychotic disorder (including schizophrenia) under specialist supervision, carefully balancing effectiveness, side-effects and individual preference. Conditional recommendation. Low certainty of evidence.
PSY6 (update)	**Psychotropic medicines (antipsychotic medicines, namely aripiprazole, olanzapine, quetiapine, risperidone; and mood stabilizers, namely lithium) should be considered under specialist supervision for adolescents with bipolar disorder (current episode manic), carefully balancing effectiveness, side-effects and individual preference.** Conditional recommendation. Very low certainty of evidence.
PSY7 (update)	**7.1 Oral antipsychotic medicines (namely aripiprazole, haloperidol, olanzapine, paliperidone or quetiapine) or mood stabilizers (namely carbamazepine, lithium, valproic acid [sodium valproate]) should be offered to adults with bipolar disorder (current episode mania), carefully balancing effectiveness, side-effects and individual preference.** Strong recommendation. Low certainty of evidence.
	7.2 Valproic acid (sodium valproate) should not be used in women and girls of childbearing potential, owing to the high risk of birth defects and neurodevelopmental disorders in babies in utero. Strong recommendation. Low certainty of evidence.
PSY8 (update)	**8.1 Mood stabilizers (namely carbamazepine, lithium, valproic acid [sodium valproate]) or oral antipsychotic medicines (namely aripiprazole, olanzapine, quetiapine) should be considered for maintenance treatment for adults with bipolar disorder in remission, carefully balancing effectiveness, side-effects and individual preference.** Conditional recommendation. Low certainty of evidence.
	8.2 Valproic acid (sodium valproate) should not be used in women and girls of childbearing potential with bipolar disorder in remission, owing to the high risk of birth defects and neurodevelopmental disorders in babies in utero. Strong recommendation. Low certainty of evidence.

TABLE 1. Summary of recommendations

Module and recommendation number	Recommendation Strength of the recommendation and certainty of the evidence
PSY9 (update)	**Fluoxetine, olanzapine, quetiapine, valproic acid (sodium valproate) or venlafaxine should be considered for adults with bipolar depression. If fluoxetine or venlafaxine are chosen, they should be co-administered with a mood stabilizer (namely quetiapine, olanzapine, carbamazepine, valproic acid [sodium valproate], lithium).** Conditional recommendation. Very low certainty of evidence.
PSY10 (update)	**Treatment based on cognitive behavioural therapy (CBT) should be considered for adults with psychotic disorders (including schizophrenia) in the acute phase of the condition where sufficient specialist support is available.** Conditional recommendation. Moderate certainty of evidence.
PSY11 (update)	**Psychosocial interventions – namely family interventions, family psychoeducation, psychoeducation and cognitive behavioural therapy (CBT) – should be offered to adults with psychosis (including schizophrenia) during the maintenance phase, either alone or in combination.** Strong recommendation. Moderate certainty of evidence.
PSY12 (update)	**Individual psychological interventions – namely cognitive behavioural therapy (CBT), family psychoeducation, medicine adherence therapy, online psychoeducation or psychoeducation – should be considered as adjunctive to pharmacological interventions in the treatment of adults with bipolar disorder in remission.** Conditional recommendation. Low certainty of evidence.
Self-harm and suicide (SUI)	
SUI1 (new)	**Safety planning type-interventions, i.e. interventions based on principles of safety planning which are multicomponent or supplemented with follow-up or support, can be considered.** Conditional recommendation. Very low certainty of evidence.
SUI2	The evidence regarding effectiveness of stand-alone media campaigns (to raise awareness and sensitize the general public about suicide and its prevention) in reducing deaths from suicide, suicide attempts and acts of self-harm is **insufficient to make a recommendation.**
SUI3 (new)	**Stand-alone digital interventions based on evidence-based interventions such as cognitive behavioural therapy (CBT), dialectical behaviour therapy (DBT), problem-solving therapy (PST) and mindfulness should be considered as support for persons with suicidal thoughts.** Conditional recommendation. Low certainty of evidence.

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