prolonged beyond what is reasonable. Patients with dementia may fit this profile.

These principles are exemplified in the content and usefulness of the AD.

Wilder et al.[8] and Srebnik et al.[9] show that individuals with mental disorders accept neuromodulators and atypical antipsychotics better, refusing classic antipsychotics and lithium more frequently. Many professionals believe that the patients will reject *all drugs*; in fact, this does not generally occur.[8] The reasons for drug refusal are: negative effects, feeling drugged and being incapable of carrying out activities of daily living.[9]

At any rate, freedom of choice in treatment and knowing its contraindications and the importance of continuing with it improve drug adherence; this in turn reduces the number of recurrences, because it represents a motivation for following the treatment.[9] It is also a reason for choosing or refusing decisions about hospitalisation or contact persons for the patients while they are hospitalised.[10]

The use of an AD reduces coercive measures, as the medical team and the patient trust each other. In addition, establishing a proxy increases the possibilities of respecting the patient's desires and the individual will feel *empowered* by this.

Through all of this, we achieve respect for the individual (autonomy), we seek greater benefits (better drug compliance, etc.) and we avoid future harm (recurrences, coercive measures and so on). Freedom of choice in treatment can help to reduce the application of undesired treatments, and it is only fair that this should happen.

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A new assessment method of posttraumatic psychiatric pathology☆

Un nuevo método de valoración de la enfermedad psiquiátrica postraumática

Dear Editor,

In 2011 there were 94,920 petty offences for lesions, 136,907 crimes against people's life, integrity and liberty,[1] 11,347 seriously wounded individuals and 104,280 individuals with serious injuries caused by traffic accidents.[2] Consequently, 347,454 individuals presented physical and/or mental lesions. Posttraumatic mental disorder (PTMD) is a disorder triggered by an external agent (of physical or mental nature) that can involve legal and economic repercussions. For legal assessment of PTMD, you need to know the type of lesion, its seriousness, the treatments received, its progression, time periods required for recovery and, principally, the individual's functionality once ''lesion stability'' is achieved; that is, the situation in which there is no possibility of improvement because all the scientifically accepted treatments have been applied. This implies that the both the expert and psychiatric reports have to focus on the diagnosis, on the seriousness and on the repercussion that the disability causes in the individual's life. There are some unique characteristics in PTMD[3]: (1) it can be produced with or without brain injury; (2) experiencing the trauma can trigger or worsen symptoms, and (3) there can be disproportion among trauma, symptoms and functionality.

To unify the parameters used to assess injuries, the use of required scales has been spreading. Although these scales may be imperfect and incomplete for quantifying personal injuries,[4] they have approached functionality, attempting to make a separation from the symptoms.[5] Among European Union members, until 1995 only Belgium, Spain, Greece and Portugal applied official scales for classifying or quantifying personal injury from road accidents.[6] The other countries

☆ Please cite this article as: Guija JA, Medina A, Giner L, Lledó C, Marín A, Arechederra JJ, et al. Un nuevo método de valoración de la enfermedad psiquiátrica postraumática. Rev Psiquiatr Salud Ment (Barc.). 2015;8:245–250.

have used non-official scales, such as Mélennec's[7] French scale, the International Classification of Functioning, Disability and Health[8] or the ''permanent impairment'' guide published by the American Medical Association.[9] In Spain, what are called psychiatric syndromes, as well as their scoring, are currently covered by a scale including the stipulations of Law 34/2003 (on modification and adaptation to Community legislation of private insurance companies),[10] Community regulations on private insurance legislation, and Legislative Royal Decree 8/2004, of 29 October (approving the restated text of the law on civil responsibility and insurance in motor vehicle circulation.[11] There are several difficulties involved in applying this scale. Firstly, the terminology used does not conform to current psychiatric classifications (the International Classification of Diseases [ICD]-10 or the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition [DSM-5][12,13]). Secondly, the scale omits the specification of the procedure for establishing a score range (except in en el organic personality disorder). Finally, the margins are narrow and the score is limited with respect to mental sequelae[14] (except for, once again, organic personality disorder). Given all of the preceding, a single sequela can receive a different score depending on the experience and knowledge of the individual examining the patient.

Consequently, we present a PTMD scoring procedure that adapts the current scale to the ICD-10 nosology[12] and specifies an assessment method that unifies PTMD scoring. This procedure does not involve a modification of the present scale; it represents a clearer, more unified use of it.

Methods

A work group was established, consisting of a set of experts (2 judges appointed by the General Council of the Judiciary and 4 psychiatrists appointed by the Spanish Foundation of Psychiatry and Mental Health, of which 2 were, in addition, medical pathologists). This work group prepared an initial draft procedure, which different professional forums then discussed. An example is *Documentos Córdoba 2011*, a meeting of law professionals (judges, public prosecutors and lawyers) and psychiatrists, published by the Spanish Foundation of Psychiatry and Mental Health.[15] There were several presentations about the legal and psychiatric need to unify the traffic scoring scale, discussing the proposal presented by the work group. This proposal was unanimously accepted and then a small legal modification was incorporated. Later, following the same method, it was presented at the 15th National Psychiatry Congress (Oviedo, 2011), at a monographic meeting (Sevilla, 2011), in collaboration with the Centre for Excellence in Forensic Research in Andalucía, about the subject with 25 forensic doctors from different autonomous communities in Spain, at which the authors (judges, psychiatrists and psychiatrists-forensic doctors) presented the reasons for the procedure; and, finally, at the 16th National Psychiatry Congress (Bilbao, 2012).

Procedure

Evaluation prior to scoring

Expert evaluation should be based on ''lesion stability'', the time when the lesion or mental disorder does not progress positively in spite of the treatment prescribed. Childhood psychiatric signs and symptoms need to be framed, for their evaluation, in the overall attitude of the parents in the face of the causal traumatic facts.

Diagnoses: concordance with the current scale

As indicated previously, the ICD-10 diagnoses[12] referring to mental diseases are linked to the psychiatric syndromes included in the official scale. To do so, the scale subsections would be changed to the current diagnoses (Table 1). To make application possible, the diagnosis has to fulfil the same criteria as those gathered in the ICD-10.[12]

When a diagnosis of mental sequela had occurred previously, it will be recorded as aggravation, and symptom intensity and degree of disability will be calculated as the difference resulting from the mental sequelae before and after the event.

Indication of the severity of the symptoms

The severity of the posttraumatic suffering will be evaluated according to the number and intensity (temporal frequency) of the symptoms present reported in the clinical history and examination, always based on the nosographic criterion description established for each entity in the ICD-10 international classification.[12] To diagnose with this classification, the subject evaluated has to fulfil the minimum criteria specified for each entity. Starting from these minimums, the type of severity will be indicated in the following gradients:

- Moderate: up to 40 points. Subject fulfils the minimum number of required criteria established in the ICD-10 for diagnosis.
- Intense: up to 60 points. Exceeds the symptoms by 20% over the minimums required for this diagnosis.
- Very intense: up to 80 points. Exceeds the symptoms by 40% over the minimums required for this diagnosis and/or 1 of them is extremely severe.
- Extreme: 100 points. Has the maximum number of symptoms described for this diagnosis and/or several of them are extremely severe.

The category ''Mild'' would be eliminated, given that it supposes the existence of isolated psychopathological symptoms and/or indeterminate and diffuse mental distress that do not cause a decrease in the subject's functional capacities, with normal activities being maintained.

Degree of disability produced by the symptoms present

Disability means the difficulties for a subject's autonomous life and/or the negative repercussions on their working life.[16] In this section we assume the specifications of Royal Decree 1971/1999, of 23 December, on the procedure for recognising, declaring and rating the degree of disability,[17] and its posterior correction.[18]