

**Meeting of the International Advisory Group  
for the Revision of ICD-10 Mental and Behavioural Disorders  
24 – 25 September 2007, Geneva, SWITZERLAND**

**Meeting Summary Report**

The second meeting of the International Advisory Group (AG) for the Revision of ICD-10 Mental and Behavioural Disorders was held in Geneva during 24 – 25 September 2007. The Advisory Group was constituted by WHO with the primary task of advising WHO on all steps leading to the revision of the mental and behavioural disorders classification in ICD-10 in line with the overall revision process. The list of participants, including the special invitees, are provided in the Annex. The meeting was chaired by Dr. Steven Hyman. Dr. Geoffrey M. Reed acted as rapporteur.

This summary presents the conclusions reached within the context of the terms of reference for the Group.

**1. Progress on the overall ICD revision process**

The AG is aware of the nature of the overall ICD revision process of which the revision of the Mental and Behavioural Disorders chapter is a part. The Advisory Group will need to consider its plans in relationship to the objective of the overall ICD Revision Steering Group that a draft version all chapters be submitted during 2010.

Specific issues to be considered include:

1. The applicability to the mental disorders chapter of definitions of disease, disorder, syndrome and other terms being developed as part to the overall revision process, and the consistency of these definitions with the draft definition of mental disorder endorsed by the AG in January, 2007.
2. The compatibility of the criteria developed for mental disorders and the nature of additional information provided as part of the mental disorders classification with the attributes for ICD entities that have been proposed by the Classifications and Terminology team (e.g., site, cause, impact, related interventions, settings of use).
3. The feasibility of a telescoping structure for the mental disorders chapter (i.e., primary care version → version for clinical use by mental health professionals → research version).

**2. Rules and procedures**

The AG agreed on rules and procedures in relation to the above-mentioned topics. The AG noted the more specific disclosure requirements and definitions included in the revised Conflict of Interest Declaration form, and noted that while a potential conflict may not be a problem if it is reported and managed appropriately, not reporting such a potential conflict is a problem. AG members agreed that they would notify WHO of any new professional positions, commitments, or relationships that pose a potential conflict and provide updated Conflict of Interest Declarations accordingly.

The AG noted that it is to the benefit of the revision process for AG members to make presentations at professional and scientific meetings in order to provide information about the revision and facilitate opportunities for participation and input. AG members agreed that they would notify WHO of any such participation and submit the title of any planned program for WHO for review prior to its being finalized to safeguard against any real or perceived misrepresentation.

Similarly, it is reasonable for AG members to be involved in publications in scientific and professional journals that relate to the diagnosis and classification area. However, to avoid any real or

perceived misrepresentation, the AG members agreed that they would notify WHO and provide WHO with an opportunity to review any such publications prior to their being submitted for publication.

The AG also agreed that programs and publications by AG members that relate to diagnosis and classification and more specifically to the revision process should include a disclaimer that clearly indicates that while the author is a member of the WHO AG, the views expressed are not of WHO or of the Advisory Group and that the content of the program or publication does not in any way represent WHO policy.

### **3. *Progress on coordinating groups***

The AG reviewed, revised and approved the work plans for the following coordinating groups:

- 1) Global Scientific Partnership Coordinating Group (lead, Dr. Norman Sartorius);
- 2) Stakeholder Inputs and Partnership Coordinating Group (leads, Drs. Juan Mezzich and Benedetto Saraceno);
- 3) Resource Mobilization Coordinating Group (leads, Dr. Steven Hyman and Dr. Shekhar Saxena); and
- 4) ICD-DSM Harmonization Coordinating Group (leads, Dr. Benedetto Saraceno and Dr Shekhar Saxena).

Details of these coordinating groups can be obtained from WHO.

### **4. *Differences between ICD-10 and DSM-IV***

The AG agreed that, for a variety of reasons, the ideal situation would be for the mental and behavioral disorders in ICD-11 and DSM-V to be exactly the same. However, the AG also acknowledged that this ideal may be difficult to achieve.

In most cases, it would likely be possible to separate the differences between the two evolving systems into the categories of substantive and trivial. There is universal agreement that the trivial differences should be eliminated. However, seemingly trivial differences in criteria may still translate into large effect on prevalence, leading to a serious impact on administrative, health record, and reporting systems. Such changes also may have significant implications for research and the ability to interpret the existing knowledge base.

A strategy needs to be articulated for how both substantive and trivial differences should be negotiated as a part of ICD-DSM harmonization. The ICD-DSM Harmonization Coordinating Group will attempt to categorize the evolving differences between the two systems in terms of their substantive importance and will formulate a set of principles and suitable strategies to identify the reasons for these differences and possible actions to achieve harmonization. The AG expressed strong support for the harmonization effort. It also indicated that there may be valid reasons for differences between ICD-11 and DSM-V in many areas and that these differences should be as far as possible resolved by evidence, e.g. through field trials.

### **5. *Literature search on diagnosis and classification***

WHO has initiated a literature search of published work with relevance to revision of diagnosis and classification since the release of ICD-10. Through a specified, rule-governed search process via Medline, 1132 relevant articles most likely to have direct relevance to the revision process were identified. These are currently being collated, rated for relevance, and stored in a database for use during the revision process.

It will be important to consider how this database may be used to supplement other available materials. A process should be established for maintaining and contributing to the literature base in a systematic way. For example, a part of the charge of the Global Scientific Partnership Coordinating

Group is to identify relevant literature that may not be represented in mainstream scientific publications. How this information can be added to the database should be considered. In addition, Medline will not have picked up some relevant bodies of literature (e.g., psychological literature on diagnostic constructs), so it may be useful to conduct equivalent searches of other databases using the same search methodology. The AG invited volunteers to extend and expand this literature search.

#### **6. *Diagnosis and classification system for primary care***

The AG noted that the ICD-10 and DSM systems for the classification of mental disorders in primary care had been adapted from systems designed for specialty use. They were not developed in and for primary and general health care settings. As such, they fail to capture the typical characteristics of patients seen in primary care settings. Patients in primary care settings often present with subthreshold, co-occurring, and mixed mental health syndromes that are not adequately covered by the more specialty-oriented systems of mental disorder classification in the ICD-10. In addition, the classification system also fails to address adequately the relevant cultural factors in these patients' presentation, having been developed primarily in Western countries. Further, they do not adequately address issues of symptom severity, chronicity, and functional impairment.

The AG agreed that the primary care version of the ICD classification of mental disorders be nested within and developed simultaneously with, rather than adapted from, the specialist versions. This means that it will be extremely important to pay careful attention to the validity and usefulness of the larger, higher-order categories. Further, linkages with classification and assessment systems used in primary care should be considered as a part of the revision process. Mechanisms for capturing parameters that are particularly important in primary care—e.g., disability, chronicity, urgency—should also be considered.

#### **7. *Research diagnosis versus clinical care diagnosis***

The AG noted that the current classification contains approximately 150 different diagnoses, each requiring between 10 and 30 pieces of information. This substantially exceeds the level of information that the human brain can easily process. More than half of all diagnoses in clinical practice are assigned to NOS categories, suggesting that specific criteria lists are frequently not used. One of the aims of the ICD should be to provide a more clinically useful classification that will actually be used as intended, thereby providing more valid information.

However, while clinicians tend to value flexibility and ease of use, researchers may require a greater degree of precision in order to specify research populations clearly and in a replicable manner. A possible solution to this would be to develop a two-tiered classification for clinical and research use. The clinical version might be constructed around brief prototypes, while the research version would contain more specific criteria and be more similar to the current research classification. The AG noted that there is a body of research that indicates that the prototype approach is more consistent with how clinicians, particularly in primary care, think and make decisions than is the current format of criteria lists. The AG also questioned the assumption that a more highly specified version is the gold standard for classification, as it might be argued that this assumption has had a negative effect on research. A classification system with more clinical utility is likely also to be one that has more diagnostic validity. It was also noted that ICD-8 had been structured in a way that bore some resemblance to a prototype system, and had been highly popular.

The AG was receptive to the idea of using prototypes as a central component of a diagnostic classification for mental health clinicians, as well as in primary care. However, there are several issues that need clarification. It is unclear whether prototypes will be sufficiently useful for clinical use in a variety of settings and by a variety of care providers, including in primary care. It is also unclear how the prototypes would relate to criteria in the research version. However most of these questions could be addressed by empirical research, including field trials. Overall, the AG supported further exploration of this possibility.

## **8. Severity criteria in ICD and DSM**

The AG noted that in ICD-10, level of severity can be indicated in relation to a very limited number of diagnostic categories, most importantly depression and its variants (e.g., depressive episode, recurrent depressive disorder), mental retardation, and dementia (*Diagnostic criteria for research only*). In these cases, there is persuasive evidence that different types of treatment or levels of care are appropriate for different levels of severity. The same argument may apply to a variety of other mental disorders, though not to all.

The AG agreed that it is important to be able to identify the level of severity within the diagnostic process when severity is related to the form of intervention indicated, or where preventive measures are appropriate in early stages of the condition. One option would be to identify those disorders for which there is specific evidence of differential treatment effectiveness based on severity, so that levels of severity or a dimension of severity can be developed for these categories as a part of the diagnostic system. This will facilitate future research on interventions suited to a range of severity. Another option would be to provide a severity dimension that can be used broadly, across a wide range of disorders.

## **9. Use of ICD-10 Mental and Behavioural Disorders Classification**

The AG noted the available information on use of ICD for mental and behavioural disorders in selected countries. It recognized the value of existing research and experience on the use of ICD, as well as the need for additional research to answer a number of specific questions. For example, how many governments use ICD-10 or are likely to use ICD-11 for reimbursement purposes? Which scientific journals do or do not publish articles that use the ICD as a basis for classification in research? To what extent is research currently funded based on the ICD? To what extent do national professional societies promote the use of classification systems? In what countries are there requirements to use both ICD and DSM for different purposes? What are the issues specific to use of ICD categories and criteria by various professional provider groups? Mechanisms for collecting such information need to be considered as part of the revision process, including the field trials.

## **10. Contribution of epidemiology**

The AG agreed that psychiatric epidemiology can make an important contribution to the revision of the mental and behavioural disorders classification. While the World Mental Health Survey is an important source of information, it should not be viewed as the only source of relevant epidemiological data. In addition, the AG believed that the best approach is to use epidemiological data in the service of addressing targeted questions rather than allowing trends in epidemiological data to drive the nature of the classification.

The AG requested selected members to work with WHO secretariat to develop specific questions related to matters of concern to the revision process that can be addressed using available epidemiological data. These members were also requested to identify research groups, including the World Mental Health Survey Group, that will be able to provide data to respond to the specific questions. The AG recognized additional resources will need to be generated in order to collate and analyse data to answer some of these questions.

## **11. Use of APIRE material**

The AG agreed that the scientific material already compiled by APIRE is a substantial resource to be used by for the ICD revision process. The AG further expressed the need to build on this information and evidence base especially to collect additional material arising in regions and languages that are often not covered by the usual review of published literature. This is especially important in view of the international scope of the revision process for ICD.



## **2nd Meeting of the Advisory Group for the Revision of ICD-10 Mental and Behavioural Disorders**

**24 - 25 September 2007 Geneva, SWITZERLAND**

Venue: Conference Room B, 3rd floor, WHO Main building

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