

**World Health Organization
Department of Mental Health and Substance Abuse
Geneva, Switzerland**

Meeting of the International Advisory Group
for the Revision of ICD-10 Mental and Behavioural Disorders
1 - 2 December 2008, Geneva, Switzerland

Meeting Summary Report

The fourth meeting of the International Advisory Group (AG) for the Revision of ICD-10 Mental and Behavioural Disorders was held in Geneva during 1 - 2 December 2008. A list of participants is provided in the Annex. The AG was constituted by WHO for a period of 2 years (2007 – 2008) 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.

This Summary Report provides a summary of the conclusions reached during the meeting

1. Opening Remarks

The meeting was opened by Dr. Benedetto Saraceno, Director, Department of Mental Health and Substance Abuse, WHO. Dr. Mario Maj was introduced as the new representative of the World Psychiatric Association (WPA) on the AG, and Dr. Ann Watts as the new representative of the International Union of Psychological Science (IUPsyS). Dr. Saraceno announced that the International Advisory Group for the Revision of ICD-10 Diseases of the Nervous System (Chapter VI) has been approved and members appointed. The Department of Mental Health and Substance Abuse will manage the technical part of the revision of Chapter VI, as it is doing for Chapter V. Dr. Saraceno reminded the AG that this would be the final meeting of this group in its current composition. As noted, the AG was appointed in January, 2007 for a 2-year period.

Dr. Steven Hyman, AG Chair, discussed the growing public awareness and concern about conflict of interest issues as they relate to the development and revision of systems for mental and behavioural disorders classification. It is very important that any potential or apparent conflict of interest be clearly disclosed as required by WHO policy, but also that the AG be fully aware of all such issues so that it can manage them appropriately and transparently. Dr. Hyman suggested that it is also important to be transparent about AG members' involvement in the American Psychiatric Association's revision of its Diagnostic and Statistical Manual of Mental Disorders (DSM), in the light of discussions about harmonization and copyright issues that may have financial implications.

Regarding the formation of a new AG, the AG was aware of the importance of appropriate representation by region, gender, and profession. In addition, the AG agreed that it would be useful to select AG members who have an institutional base that will facilitate their implementation of the types of testing programmes in multiple settings, countries, and cultures.

2. Update on proposal for large groupings of mental and behavioural disorders: Overview of Psychological Medicine articles

Presenter: *Dr. David Goldberg*

Dr. Goldberg described key changes and additional specifications in the proposal for large groupings of mental disorders discussed at the AG meeting in March, 2008. Manuscripts based on this proposal are now in press in *Psychological Medicine*. The current version of the proposals includes five clusters of disorders. Each of these clusters meets some, though not all, of the validation criteria as modified from Robins and Guze by Hyman and colleagues. Similarities

within the proposed clusters make it reasonable to view the different disorders within the cluster as variations on a single theme rather than separate and ‘comorbid’ disorders. The AG emphasized that decisions about an overarching architecture of categories will need to be made within the next year, keeping in mind WHO's emphasis on clinical utility in a broad range of settings and countries.

3. *Relevance of large groupings to ICD revision: Testing clinical utility of large groupings in low and middle-income countries*

Presenters: *Dr. Rangaswamy Thara, Dr. Oye Gureje, Dr. Maria Elena Medina-Mora, and Dr. Khalid Saeed*

Based on their experience in a variety of institutional settings in low and middle-income countries, Drs. Thara, Gureje, Medina-Mora, and Saeed were asked to describe briefly the major issues and challenges related to assessing the utility of the proposed large groups of mental disorders in those countries and settings. *Dr. Thara* emphasized that behavioral and functional descriptions would be more helpful in community settings than lists of criteria. *Dr. Gureje* pointed out that treatment of mental disorders in primary care and the need for a simpler, user-friendly system are not just issues for low and middle-income countries. *Dr. Medina-Mora* described possibilities for a range of demonstration projects, particularly in Latin America, that would provide useful information about the proposed groupings. The primary goal of these projects would be to examine clinical utility within specific cultural and economic contexts, and the types of additional support that may be needed to improve identification and treatment of mental disorders. *Dr. Saeed* suggested that there may be little correspondence between public health needs in mental health and the issues that would be addressed by a re-conceptualization of mental disorders categories along the lines of the proposed meta-structure.

4. *Relevance of large groupings to ICD revision: Testing clinical utility in other contexts*

Presenters: *Dr. Michael Klinkman, Dr. Mario Maj, Dr. Norman Sartorius, Dr. Graham Mellsop, and Dr. Toshimasa Maruta*

The next series of presentations focused on the potential utility of the proposed large groups of mental disorders and possibilities for testing their clinical utility in a variety of other contexts, including professional societies and national or regional networks. *Dr. Klinkman* discussed the potential utility of the proposed large groupings in primary care. WONCA's International Classification of Primary Care (ICPCP) provides a limited number of categorical mental disorders diagnoses (e.g., depressive disorder), as well as a variety of commonly presented symptoms and a list of social problems. *Dr. Maj* suggested that the proposed large groupings may be no simpler and no less confusing to the average clinician than existing clusters, and may not represent the natural world any better. *Dr. Sartorius* discussed the possible role of the Global Scientific Partnership Network in testing the global applicability of the proposals. *Dr. Mellsop* pointed out that even if the evidence for the proposed clusters is mixed if examined in relationship to the Hyman validation criteria, it may compare favorably to an evaluation of the current nine groupings against the same validation criteria. *Dr. Maruta* described efforts underway in Japan to prepare for field trials, and identified several questions that should be addressed.

Conclusions, Items 2 - 4

The AG emphasized that in considering these and other proposals for the ICD, it is important to make a distinction between validity and utility. This distinction is useful even though they can be considered as overlapping constructs. Utility must always be considered with respect to a particular purpose (e.g., clinical, public health, communication, education, research). From a research perspective, the AG considered the large groupings proposal to be useful as a hypothesis. From a clinical perspective, grouping disorders for which the same interventions are effective (e.g., most of the emotional disorders) will likely be helpful; groupings that do not inform assessment and treatment will be less clinically useful. While WHO views validity as an important priority for the

classification, the goal of increasing the utility of the classification for identifying and treating mental disorders and reducing associated disease burden also provides a compelling basis for making changes. The development of methods and specific plans for testing questions related to clinical utility in relevant settings should be among the priorities for work during the next year.

5. *Epidemiological evidence coordination group: Available datasets, information needs, and work plan*

Presenters: *Dr. Ronald Kessler* and *Dr. Somnath Chatterji*

The purpose of this presentation was to inform the Advisory Group of the work conducted and planned by the Epidemiological Evidence Coordination Group, specifically including the assessment of available databases for relevant epidemiological analyses, a description of analyses in process and potential future analyses, and examples of results. Activities of the group include conducting secondary analyses of the World Mental Health Survey data, designing and soliciting new data collections, and collaborating with existing networks of researchers focused on particular disorders or disorder clusters.

6. *Secondary data analyses for DSM-V*

Presenter: *Dr Darrel Regier*

Dr Regier described strategies and methods for secondary analyses of epidemiological data that are being used in the DSM revision process. To date, secondary data analyses have focused on: a) the developmental expression of disorders across the lifespan; b) differences in expression of disorders by gender and culture; c) disorder spectra; and d) the interface between mental and general medical disorders. Longitudinal data sets are being used to conduct analyses on the developmental expression of disorders. The AG requested that the results of epidemiological and secondary data analyses conducted in the context of the DSM and ICD revisions be made available to both groups.

7. *Global Scientific Partnership Network and Coordinating Group*

Presenter: *Dr. Norman Sartorius*

Dr. Sartorius described the current composition of the Global Scientific Partnership Network (GSPN) and highlighted the need for additional representation from particular geographic regions—most particularly Latin America and Southeast Asia—and with specific types of experience and expertise, including experts with professional backgrounds other than psychiatry. AG members and professional societies will make recommendations for additional members for the GSPN. The WHO Secretariat will work with Dr. Sartorius to improve representation.

8. *Broadening revision inputs*

a) *Summary of comments received from ICD Update and Revision Platform*

Presenter: *Dr. Geoffrey Reed*

Dr. Reed reported that the Update and Revision Platform is easy to use and works extremely well, and again commended members of the Classifications, Standards, and Terminology group for their work on it. He provided a summary of comments received to date, which have generally been highly specific proposals in areas of particular professional or personal interest to the commenter.

b) *Soliciting input from international professional societies*

Presenters: *Dr. Mario Maj (WPA)*, *Dr. Ann Watts (IUPsyS)*, *Dr. Nicholas Hardiker (ICN)*, *Dr. Michael Klinkman (WONCA)*, and *Mr. Rolf Blicke-Ritter (IFSW)*

Dr. Maj described how World Psychiatric Association (WPA) member societies could provide a cross-cultural perspective in the several important areas related to the revision. *Dr. Watts* described how the International Union of Psychological Science (IUPsyS) could help to expand revision input by identifying and nominating global experts, providing comments through a global, electronically-based network of national and regional members, and affiliates; and participating in field trials. *Dr. Hardiker* described how the International Council of Nurses (ICN) can provide access to nurses' experience with classification in the delivery of mental health services. *Dr. Klinkman* described how the World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (WONCA) can contribute to the revision effort, for example by helping the Advisory Group to re-conceptualize somatoform presentations and risk factors for mental illness, and clarifying which aspects of psychosocial factors need to be revised. *Mr. Blickle-Ritter* indicated that the International Federation of Social Workers (IFSW) can collect information relevant to the ICD revision from social workers across countries.

As the need arises, the AG or the WHO Secretariat will direct specific, targeted question to the professional societies, and may also want to ask for background literature or scientific information. However, professional organizations are also encouraged to initiate input regarding the direction, method, and content of the revision process based on the perspectives of their membership and the aims of their organizations.

9. ICD/DSM Harmonization Group

Presenters: *Dr. Darrel Regier* and *Dr. David Kupfer* (APA); *Dr. Benedetto Saraceno* and *Dr. Shekhar Saxena* (WHO).

Dr. Hyman began this discussion by raising the issue of how the international community might best be involved in the DSM process. To the extent that ICD and DSM diverge, this may create unintentional divergence in treatment, research, and epidemiology. It is often clear that the two systems agree about the nature of the phenomenon that categories represent, but approach them in slightly different ways. This challenge is elevated when groups begin to revise individual criteria sets, as research has demonstrated that relatively minor differences in criteria can have a large impact on prevalence estimates.

Speaking for the APA side of the harmonization agenda, Dr. Regier placed the current situation in a historical context. While there had been early collaboration between ICD and DSM for DSM-I and DSM-II, DSM-III made a major break and as a result was substantially different from ICD-9. In retrospect, this represented a failure to communicate and collaborate. At the same time, it is possible that DSM-III was so different from ICD that it would have been very difficult for WHO to obtain the necessary agreement to make so dramatic a change in any case. Dr. Regier indicated that APA had made a major effort to make the DSM process as collaborative as possible beginning in 1999, and characterized the DSM process as cross-cultural and interdisciplinary. He described the DSM process as a very transparent one; the proceedings from all of the working conferences have been published or are in process. He emphasized the importance of an advisory review process that can help to make sure that DSM-V will fit the needs of the world, cross-culturally, and to make sure that it can be integrated with other components of the ICD. Dr. Regier suggested that a unique contribution that WHO can make is to facilitate an international consensus that avoids some of the risks of independent national classifications.

Dr. Kupfer, also speaking from the APA side of the harmonization issue, emphasized that he saw communication between APA and WHO as having been very successful, with open conversations, active involvement, and observer status at one another's meetings. There continues to be discussion about larger clusters as a part of the DSM process, which is a theme that came out of the WHO/APIRE Public Health conference. A joint discussion about the issue of impairment is now becoming more prominent. The DSM effort is now looking into adopting or creating measures of impairment that are relatively independent of each diagnosis. This should

help tremendously, particularly with co-morbidity. It is important that such instrumentation efforts not be undertaken separately, but as a part of a collaborative work plan.

Dr. Saraceno, speaking from the WHO side of the harmonization issue, raised a number of concerns related to harmonization. As Director of the WHO Department of Mental Health and Substance Abuse, he routinely receives communications from global leaders in the field. In recent months, the topic of the ICD revision has been prominent, and the issue of harmonization with the DSM has been raised frequently. The importance of harmonization is widely endorsed, but many have emphasized that the two processes should be parallel and independent and that WHO's development of ICD should not be substantially influenced by the DSM process. Some have specifically criticized APA's and WHO's attendance at one another's revision meetings, pointing out that other classification groups—Chinese, Cuban, etc.—are not treated equivalently. There has also been criticism of cross-membership on DSM and ICD working groups. These issues regarding the interaction of the ICD and DSM processes will need to take into account, both in terms of their substance and in terms of perception, even in the overall context of harmonization as a general goal.

Dr. Saxena, also speaking on behalf of WHO, acknowledged a history of successful collaboration between WHO and APA, including the recent conferences, but also noted significant challenges. The mandates, organizational requirements, and interests of WHO and APA do not overlap entirely and cannot be put aside. The constitutional responsibility of WHO for ICD is a unique and serious one. As the ICD process goes forward, there will be a demand for increasing specificity, which will create more difficulties if uniformity is seen as the most important goal. There are also issues related to copyright and publication revenues. There was a Memorandum of Understanding between APA and WHO in 1990 regarding ICD-10 and DSM-IV, which seems to have worked well. However, changes in organizational priorities, global health care, and technology suggest that it may not be a simple matter to achieve a similarly workable agreement in the current context. Commercial issues may become more prominent the greater the degree of harmonization achieved.

10. Functional Status, Disability, and Diagnosis

Presenters: *Dr. Geoffrey Reed* and *Dr. Somnath Chatterji*

The purpose of this session was to articulate the implications for the ICD revision of the model of functioning and disability provided by the International Classification of Functioning, Disability, and Health (ICF). In particular, this was considered in relation to the AG's expressed goal of separating diagnosis and functional status. In examining the differences between ICD and DSM, the 'clinical significance' criterion—most often operationalized in terms of functional status—is one of the most important source of differences between the two systems, and there is evidence that this is largely responsible for difference in prevalence estimates using the two systems. A major source of confusion in this discussion is that there is no agreement about the meaning and use of terms—e.g., functional status, impairment, disability—so that the degree of consensus about these issues is difficult to evaluate.

Signs and symptoms of most diseases or health conditions involve impairments in body functions or body structures (e.g., insulin deficiency, spinal cord injury, high blood pressure, loss of vision, impaired reuptake of serotonin). Therefore, impairments in body functions and structures—even though the ICF includes these in its conceptualization of disability—must be allowable as diagnostic criteria. Moreover, there are some important symptoms of mental disorders that in the ICF would be considered to be part of Activities and Participation. Examples include disturbances in social-emotional functioning in autism, 'persistent refusal to accept medical advice' in somatization disorder, and such behaviours as lying, breaking the law, putting one's job at risk, and acquiring debts in pathological gambling. In some cases, these may be defining features of a disorder that are assumed to correspond to some underlying brain process that cannot be directly observed. In other cases, these may be considered observable manifestations of a

disorder in a particular environment. And in still others, these may in fact be best conceptualized as consequences of a disorder.

The AG noted that there are at least two separable projects related to the interaction of mental disorder and disability. The first is the question of how disability related to mental disorders should be assessed as a separate construct. The second is an evaluation of the extent to which disability is already embedded in mental disorder criteria and a consideration of whether at the criteria level disorder and disability can be teased apart. A part of this second project concerns the separation of disability and disorder severity, and whether this would be the same for all disorders. The AG affirmed that it was important to continue to work on issues related to the relationship of diagnosis, functioning, and disability. Where possible, it will be helpful to do this collaboration with the DSM revision given the relative importance of this issue among the differences between ICD and DSM. However, the AG made a distinction between the discussion of how criteria are defined in relationship to disability, which is of direct concern to the ICD revision effort, and the instrumentation of disability within the DSM as a more general issue. This second area is not as directly relevant to the ICD mental and behavioural disorders revision effort.

11. Closing Remarks

Dr. Saraceno described his view of the needs for the reconstituted AG that will be appointed in 2009. For the first 2 years, the AG has really focused on conceptual discussions and decisions about the overall direction of the ICD revision. This phase of the work is over. The next stage will require more concrete and specific decisions about the shape and content of the classification. While there are specific needs for regional and gender representation that WHO must satisfy, there is also a great need to consider representation of expertise in relation to the tasks that will be required over the next 2 years. There must be an ability to consult more effectively and efficiently with external people who can provide specific and needed inputs without having to be members of a continuing advisory structure. There will also be a need for smaller, technical groups to conduct specific, targeted pieces of work. A more flexible model will be required, as well as people who will actually be able to assist with implementation and be accountable for those tasks. Dr. Saraceno extended WHO's sincere thanks to the group and to the Chair for their work over the past two years.



4th Meeting of the Advisory Group for the Revision of ICD-10 Mental and Behavioural Disorders

1 - 2 December 2008 Geneva, SWITZERLAND

Venue: Conference Room M.105 (1st day) and conference room D (2nd day)
WHO Main building

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