Editorial

Reducing Disease Burden through the Revision of ICD-10 Mental and Behavioural Disorders

Among the constitutional responsibilities of the World Health Organization (WHO) are: (i) establishing and revising international nomenclatures of diseases, causes of death and public health practices; and (ii) standardizing diagnostic procedures as necessary.[1] WHO is currently revising the International Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10),[2] and ICD-11 is scheduled for approval by the World Health Assembly in 2014. The ICD is the international standard for health information for assessment and monitoring of mortality, morbidity and other health parameters. The ICD revision must be responsive to a full range of clinical, public health, educational, research, policy and statistical applications; be based on the best available scientific knowledge; and keep pace with advances in healthcare that can improve its reliability, validity and utility.

This commentary focuses on the development of the ICD-11 classification of mental and behavioural disorders, being led by the WHO Department of Mental Health and Substance Abuse. The Department's highest priority is to help WHO member countries, particularly those with fewer resources, to reduce the disease burden and disability associated with mental disorders. This priority shapes the Department's approach to the ICD revision. Neuropsychiatric disorders account for 13% of the total global disease burden and disability, more than any other category of non-communicable disease.[3] A minority of people with even severe mental disorders—fewer than 25% in developing countries—receive any treatment at all,[4] and only a small percentage of such treatment is provided by psychiatrists.[5] Worldwide, people with mental disorders are far more likely to receive treatment in primary care than in specialty mental health settings.[6]

India provides a useful example of these points. Neuropsychiatric disorders account for 11.6% of the total disease burden in India,[3] and conservative estimates suggest that at any given time more than 65 million people in India suffer from mental and neurological problems that require professional treatment.[7] But India has only 0.2 psychiatrists per 100 000 population, considerably below the median of 1.05 for lower middle-income countries, and less than one-fiftieth of the median for high-income countries of 10.5.[8] Although India has outstanding training programmes for psychiatrists, many leave to work in high-income countries. Other mental health professionals—psychologists, social workers, psychiatric nurses—are even scarcer in India than psychiatrists.[8] Integration of mental health services into community-based primary care settings is the only viable option for substantially increasing their availability in India, though India's past efforts in this direction have had mixed results.[9]

The WHO Department of Mental Health and Substance Abuse is working to support the integration of mental health and general medical services through two avenues. Both emphasize low- and middle-income countries, which account for 85% of the world's population. The first avenue is WHO's *Mental Health Gap Action Programme* (mhGAP).[10] Launched in October 2008, mhGAP aims to provide an integrated package of effective and cost-effective interventions for people with high-

impact, high-burden mental and neurological disorders to be delivered by non-specialist healthcare providers in primary care settings in low- and middle-income countries.

The second avenue is to provide tools to enable more widespread and efficient identification and prioritization of people with mental disorders who need treatment. This is the overarching consideration guiding the ICD mental and behavioural disorders revision, which emphasizes low- and middle-income countries for the same reason. In most countries, mental health service eligibility and treatment selection are heavily influenced by diagnostic classification. People with mental disorders are more likely to receive the services they need, if health workers in the settings where they are most likely to come into contact with the health system—by definition, primary care settings—have a diagnostic system that is reliable, valid, clinically useful and feasible. In low- and middle-income countries, primary care professionals are often not physicians, and are highly unlikely to be specialist mental health professionals.

Substantial concerns have been expressed regarding the clinical utility of current classification systems for mental disorders,[11] which generally apply to both ICD-10 and to the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*.[12] The most important contributor to the poor clinical utility of current psychiatric diagnostic systems is their extraordinary complexity, which does not appear to be necessary for many clinical applications[13] and does not support the efficient use of limited treatment resources at the clinical or country level. After developing ICD-10, WHO created a simplified mental and behavioural disorders classification for primary care.[14] However, this system's usefulness was limited because it was adapted from the specialty classification, primarily by collapsing it,[15] rather than being created based on the needs of primary care settings. Moreover, its underlying conceptual model was physician-based primary care settings in developed countries. WHO believes that there is a compelling need for a version of the ICD-11 mental and behavioural disorders classification applicable across the full range of global primary care settings. For ICD-11, WHO plans to create the primary care version simultaneously with the specialty version, based on the particular needs of these settings and the characteristics of the healthcare personnel who work in them.

Another important difference between the current and previous revisions is its acknowledgement of the key role played by the cultural framework in determining how mental disorders are experienced, presented and defined. Universality of specific categories of mental disorders and their symptoms is an inherent but unproven assumption of existing classifications,[16] with culture viewed primarily as a source of error. Very little attention has been paid to examining the discrepancies between western nosological frameworks and other systems, as these are seen as unscientific at best and superstitious folklore at worst. However, modifications of ICD-10 made in country-level classifications[17,18] are typically based on a rational, deliberative and even scientific process.

WHO is implementing several strategies to enhance the clinical utility and cultural applicability of the ICD-11 mental and behavioural disorders classification. The first strategy is an international and multilingual review of the literature to evaluate major trends, themes and areas of active debate related to the classification of mental disorders, particularly related to clinical utility in low- and middle-income countries. For example, though virtually unused in western countries, neurasthenia was for many years by far the most commonly diagnosed mental disorder in outpatient and community settings in China.[19] The Chinese conceptualization of neurasthenia attaches equal diagnostic weight to somatic, cognitive and emotional symptomatology, and in this respect differs from western diagnostic constructs. Wider application of western classification systems in Chinese psychiatric research has contributed to marginalization of neurasthenia as a residual somatoform category and its replacement by depression as a common psychiatric diagnosis. But such a change is perhaps more a function of the global impact of dominant western views (e.g. among journal editors) and pharmaceutical marketing (e.g. of antidepressants to treat depression) than a product of adequate professional debate or scientific evidence. The fact that the diagnostic

category of neurasthenia is still widely used by general physicians and psychiatric practitioners and is also widely understood by lay people in both urban and rural China[19] suggests that it has continuing clinical utility that should be examined further.

WHO's second strategy is a systematic analysis of country-level and regional diagnostic systems for mental disorders, providing important data regarding which ICD elements are endorsed by local users as useful, which are seen as lacking, and what additional categories and alternative disorder descriptions are needed. For example, the Third Cuban Glossary of Psychiatry[18] includes several categories not in the ICD-10, which focus specifically on problems related to functioning in the family environment (e.g. among people with intellectual disabilities). This is consistent with a strong cultural emphasis on family in Cuba as compared with the USA or Western Europe, but may also have significant utility for treatment planning given that the family is likely to be a key vehicle for support and social inclusion, as in many low- and middle-income countries.

Third, WHO is conducting a series of systematic field studies focusing on clinical utility and global applicability through a network of field study centres in large low- and middle-income countries, including India. Application of the classification in a broad range of primary care settings will be a particular area of focus. For both primary care and specialty mental healthcare, clinical utility studies will be designed to address three questions:

1. What should be the overarching architecture of a diagnostic and classification system at different levels of care to maximize clinical utility?
2. What disorders, conditions or problems should be included in a diagnostic system to facilitate appropriate identification and treatment of mental and behavioural disorders at each level of care?
3. How should the information for each disorder be presented for different users and settings?

WHO views India as an important partner in developing this programme. Views of Indian mental health professionals are already available to the WHO's International Advisory Group for the Revision of ICD-10 Mental and Behavioural Disorders and to other key working groups. India's size, cultural and linguistic complexity, economic and systemic challenges, and technical capacity make it an ideal place for testing the applicability of the developing classification system in real-world treatment settings and its capacity to contribute to improving the accessibility and effectiveness of services for people with mental disorders. We look forward to collaboration with our Indian colleagues on the ICD revision over the next several years, and as part of our broader effort to reduce the disease burden of mental disorders throughout the world.

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Conflicts of interest: None declared

GEOFFREY M. REED
Department of Mental Health and Substance Abuse
World Health Organization
Geneva
Switzerland
reedg@who.int

PRATAP SHARAN
Department of Psychiatry
All India Institute of Medical Sciences
New Delhi
India

SHEKHAR SAXENA
Department of Mental Health and Substance Abuse
World Health Organization
Geneva
Switzerland
