GUEST EDITORIAL: CHALLENGES OF USE OF ICD 11 IN THE MENTAL HEALTH SCENE OF PAKISTAN

SYED AZHAR ALI[1] AND MOWADAT H RANA[2]
[1]Associate Professor Poonch Medical College/CMH Rawalakot
[2]Professor of Psychiatry, Healing Triad

ABSTRACT
The active use of an international classification system in the mental health scene of Pakistan is a point to ponder. The latest ICD-11 version is in the process of gradual adoption world over. How does our mental health services respond to its use may play a crucial role in research, training, standardisation of diagnosis, provision of services, impact on health economics, and our standing in the international mental health fraternity. The effective use of a classification system amidst the existing challenges requires an active critique, clearer understanding, and an incisive debate.

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The canvas showing the mental health scene in Pakistan is a picture with several shades of grey; much more than fifty. There are state of the art mental health facilities comparable with any international institution offering a full range of services; these indeed are few and far apart. Then offcourse are the public sector mental health services ranging from custodial, old fashioned asylums, to similar but fast improving ones catching up with teaching units in depertaments of mental health, Psychiatry, Behavioural sciences, and Institutes of Psychiatry. Some district, tehsil/taalaqa, or primary care centres have psychiatrists, or trained primary health care physicians who are expected to provide drug based interventions for patients with priority psychiatric disorders, broadly categorised as dementia, psychosis, anxiety and depression, and drug abuse. The private sector has a similar range. There are several examples of private sector clinics and indoor units that provide expensive but scientifically run clinical care in aesthetic and relatively ethical settings. In sharp contrast, in the private sector, are shabby, shady, and pathetic indoor centres run in the name of rehabilitation centres, that are shameful in their practices and border on criminality as regards the standards of care.

Most mental health facilities in both public and private sector are inundated by patient load. The heavy outpatients even in teaching units in tertiary care facilities undertake the obvious route; the ‘quick disposal of cases’ through listening to symptoms, and prescription of psychotropics in most consultations lasting three to five miniutes. This model finds some modification in private settings where few clinicians take out time to dissect through the symptoms to reach to a clinical diagnosis, seek some support from radiological, laboratory, or rarely psychometric testing. The prescriptions in such settings may include some form of psychosocial interpretations, psychotherapy, counselling, informational care, or rarely a long term use of the biopsychosocial model of care. Similarly some public sector or teaching hospitals have developed psychometric labs, offer counselling and psychotherapeutic services after making diagnosis based on international classification systems (ICD AND DSM), and adhere to practice of evidence based practice of Psychiatry. Sadly, such examples are few and far apart. Most of the

above mentioned settings however do not undertake an active use of an international classification system. The predominant shade on the canvas depicting the mental health scene of Pakistan is darker grey and black with an inadequate understanding and limited or no use of an international classification system.

History of Nosology in Psychiatry:

The first classification of Diseases was approved in Chicago during the Congress of the Statistical International institute in 1893 by Jacques Bertillon. In 1955 World Health Organization`s provisional Committee was given the task to produce ICD-6. From then onwards WHO has been producing ICD with intervals of 10 years. ICD-10 was published in 1992[1]. In an effort to bridge the gap between ICD & DSM, provide evidence for higher reliability and clinical utility and to form Artificial Intelligence friendly classification system, World Health Organization introduced ICD-11 in January 2022. The latest, 11th version of ICD has thus arrived after three decades.

Latest Version: ICD 11

ICD 11 in its mental health chapter aims at identification and diagnosis of mental, behavioural, and neuro developmental disorders. This is a departure from the Cartesian separation by Emil Kraeplin of psychiatric disorders into organic disorders, followed by psychosis, neurotic disorders, psychosexual disorders and personality disorders. ICD-11 instead follows a developmental perspective. The neurodevelopmental disorders appear first and neurocognitive disorders last in classification. The grouping of disorders is instead based on shared etiological factors and phenomenology. The ICD 11 has thus brought an end to the Kraeplinian approach after a century. Other distinguishing features of ICD 11from its earlier version includes, digitalisation, a departure from the age old ‘Kraeplinian’ approach to diagnosis, to a newer lifespan-based, continuum approach, a greater sensitivity to cultural ethos, and a far more intense commitment to emphasis on functioning. A stand-out feature is the openness of the ICD 11 system in its capacity to be equally healpful for all members of a mental health team, rather than the psychiatrist alone. Clinical psychologists, social workers, and psychiatric nurses, community mental health team members, and primary care teams can all use this newer version with equal ease and find it relevant to their work.

ICD 11 distinguishes itself from all earlier versions through its seamless use of the powers of digitalisation and computation. The use of Web Ontology Language (OWL), also brings itself as close to DSM as possible. This harmonisation between these two traditionally divisive nosolgies augurs well for mental health professionals around the world and helps them communicate better.

Another feature is the provision of interconnectivity between the psychiatric, neurological, and medical disorders. A typical example of the provision of this interconnectivity and lifespan approach is a patient born with a congenital heart anomaly, developing autistic features in childhood, and schizophrenia as a young adult, leading to iatrogenic metabolic conditions like diabtetes and hypertension, eventually developing vascular dementia, and then a cerbrovascular accident. ICD 11 provides a chance to all the concerned specialists to remain interlinked with a sense of continuity of diagnosis at various stages of such a patient's entire life span. This lifespan, continuum approach is as much in use in Chapter 6 covering psychiatric, neurological and substance use diorders. Additionally, ICD-11 has some major innovations like integration of dimensional approach, with a clear inclination towards biological approach in diagnosis. This may help in the common caause for de-stigmatization of mental disorders. [2]The smart coding algorithms constructed on a common structure make it easier to connect the physical and mental disorders.

The ICD 11 describes a global categorisation covering diseases, disorders, injuries, and causes of death covering 1.6 million clinical situations. It is done through the use of 120 thousand codes, and 17 thousand categories. Not all disorders have their cognitive or culumaltive impact on functioning covered. In spite of these formidable numbers and complexities, ICD 11's online and offline versions ensure an easy training of health professionals in minimal time. This will be possible in ten different languages. Unfortunately, none of these languages are from South Asia. This version has been launched two years ago but even in NHS it will not be in full operational use till 2026. ICD 11 describes linear categories, with their morbidity , mortality, patient safety measures and primary care versions. The tools on offer to formulate a diagnosis include ICD 11 browser, coding tool , API or application planning interface. Unlike ICD 10, there are no cut offs. Instead, essential features most commonly seen in clinical practice are suggested for diagnosis, providing opportunities for integration of clinical experience into the features identified in the classification system. The controversial chapter on sexual health parts ways from the categorisation of aberrant sexual behaviours into disorders in earlier versions of ICD and are only listed as behaviours and sexual preferences that individuals may report with to a clinician.[3] Gender Identity disorders have been dropped. Dual role transvestism has been deleted due to a lack of public health or clinical relevance[4]. Similarly health anxiety or hypochondriasis are now linked with obsessive compulsive disorders. Acute stress reaction is no more a mental disorder.

Some newer categories included in ICD 11 are Complex PTSD, Prolonged Grief disorder, Catalonia, Bipolar affective disorder Type 2, Hoarding disorder, Excoriation disorder,

Gaming disorder, Melancholia, Separation anxiety disorder, Selective Mutism, Avoidant/restrictive food intake disorder, Binge eating disorder, Body integrity dysphoria, Body dysmorphic disorders, Olfactory reference disorder, Compulsive sexual behavior disorder, and Intermittent explosive disorder. Conversion disorder is replaced by Dissociative Neurological disorder; and Panic disorder and Sleep disorders are no more a separate category. Similarly Persistent mood disorders including cyclothymia & dysthymia, Rett Syndrome has been deleted from ICD-11. The lifespan approach adopted for ICD-11 meant that the separate grouping of behavioral & emotional disorders with onset in childhood and adolescence is no more. They are now distributed to other groups with which they share symptoms e:g Separation Anxiety Disorder is now categorized with Anxiety and stress related disorders. The chapter on Drug Dependence has been expanded with inclusion of more illicit drugs and new categories of drug induced mood disorder, drug induced anxiety disorder, drug induced obsessive compulsive disorder and drug induced impulse control disorder[5]. A Five-trait domain, covering Negative affectivity, Detachment, Dissociality, Disinhibition, Anakastia is used.

Embracing The Change: ICD 11 in Pakistan

Mental health professionals in general and psychiatrists in particular have so far approached the ICD 11 with a degree of caution. Alongside the rest of their fraternity from low and middle income countries (LAMICs), they feel minimal representation of their viewpoint in the document. Stuck at a different level on the ladder of evolution of Psychiatry in the world, LAMIC mental health professionals are particularly concerned about the handling of psychosexual challenges and their representation in ICD 11. Gender dysphoria awareness in Pakistan and developing countries is vastly different from how the same issue is viewed in the developed world. It is on this and several other accounts that according to a recent survey conducted in Pakistan 48.5 % of Psychiatrists believe that it is difficult to adjust with ICD-11[6].

Hope and trepidation go hand in hand among mental health professionals of Pakistan in terms of ICD-11. Mental health professionals in Pakistan are concerned about cultural sensitivity and appropriateness of this newer classification. The potential of over-diagnosis and misclassification along with worries about Artificial intelligence replacing the need of mental health professionals in diagnosing mental disorders are the main concerns of Psychiatrists in Pakistan.

Recently during the month of May, a session on ICD-11 was organized in a conference at Rawalpindi, Pakistan. The keen interest shown by the participants. valuable inputs and

critical discussion by the Psychiatrists, trainee psychiatrists & medical students in that session was very encouraging in terms of attitude of mental health professionals towards understanding ICD-11.

There is a growing need for running seminars, discussion groups, and critique sessions for the mental health professionals at the local, provincial, and national level. The Pakistan Psychiatric Society may start the ball rolling by starting a series of awareness, understanding, and critique sessions across Pakistan. There is also an urgent need to make the use of ICD 11 compulsory particularly for the public and private sector mental health teaching facilities.

The provincial mental health authorities may also play their role in starting elaborate training and teaching sessions on ICD 11across their areas of responsibility. It is only then that the psychiatric fraternity in Pakistan can start to undertake research on ICD 11 categories to influence national and international policy on the subject.

References

1. Bartolome, J. M., & Sartorius, N. (1994). Classification of mental diseases. From Bertillon to CID-10: a century of international collaboration. *Actas luso-espanolas de neurologia, psiquiatria y ciencias afines*, *22*(5), 193-199.

2. Reed, G. M., Drescher, J., Krueger, R. B., Atalla, E., Cochran, S. D., First, M. B., ... & Saxena, S. (2016). Disorders related to sexuality and gender identity in the ICD-11: revising the ICD-10 classification based on current scientific evidence, best clinical practices, and human rights considerations. *World psychiatry*, *15*(3), 205-221.

3. Bränström, R., & Pachankis, J. E. (2021). Country-level structural stigma, identity concealment, and day-to-day discrimination as determinants of transgender people’s life satisfaction. *Social psychiatry and psychiatric epidemiology*, *56*, 1537-1545.

4. Reed, G. M., Drescher, J., Krueger, R. B., Atalla, E., Cochran, S. D., First, M. B., Cohen-Kettenis, P. T., Arango-de Montis, I., Parish, S. J., Cottler, S., Briken, P., & Saxena, S. (2016). Disorders related to sexuality and gender identity in the ICD-11: revising the ICD-10 classification based on current scientific evidence, best clinical practices, and human rights considerations. *World psychiatry : official journal of the World Psychiatric Association (WPA)*, *15*(3), 205–221. https://doi.org/10.1002/wps.203543.

5. Reed, G. M., First, M. B., Kogan, C. S., Hyman, S. E., Gureje, O., Gaebel, W., ... & Saxena, S. (2019). Innovations and changes in the ICD-11 classification of mental, behavioural and neurodevelopmental disorders. *World psychiatry*, *18*(1), 3-19
6. Khan, M. N. S., Irshad, M., & Nasar, A. (2022). CLINICAL APPLICATION OF ICD-11 AND ITS UNDERSTANDING AMONG THE PSYCHIATRISTS AND POST GRADUATE PSYCHIATRIC RESIDENTS OF PAKISTAN. *Journal of Pakistan Psychiatric Society*, *19*(03).

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