GUEST EDITORIAL DOI: https://doi.org/10.63050/jpps.21.03.939 JPPS JOURNAL OF PAKISTAN PSYCHIATRIC SOCIETY WWW.JPPS.PK

CHALLENGES OF USING ICD-11 IN THE MENTAL HEALTH SCENE OF PAKISTAN

SYED AZHAR ALI KAZMI[1] AND MOWADDAT HUSSAIN RANA[2]

[1]Associate Professor of Psychiatry and Behavioural Sciences, Poonch Medical College CMH Rawalakot, Azad Jammu & Kashmir, Pakistan.
[2]Chair, The Healing Triad, Pakistan.

CORRESPONDENCE: **DR SYED AZHAR ALI KAZMI** Email: dr.azhar81@gmail.com

ABSTRACT

The implementation of the ICD-11 classification system in Pakistan's mental health services presents both challenges and opportunities for improving psychiatric diagnosis and care. There is global transitioning from ICD-10 to ICD-11 underway. Pakistan's mental health landscape is a complex mix of advanced and outdated practices. Public sector facilities vary from under-resourced institutions to emerging teaching hospitals, while private sector services range from high-quality clinics to poorly regulated, substandard care centers. Despite the availability of modern facilities, the adoption of disease classification such as ICD-11 remains virtually nonexistent; this fact results in diagnostic inconsistency and thus limited evidence-based practices. The ICD-11 compared to ICD-10 has several innovations, including a lifespan approach, enhanced cultural sensitivity, and greater integration of digital tools, which can significantly benefit clinical practice and research. However, concerns about cultural relevance and the adequacy of training in Pakistan persist, with a significant portion of the psychiatric community expressing uncertainty about its implementation. This paper discusses the historical development of psychiatric nosology, the features of ICD-11, and the unique challenges faced by mental health professionals in Pakistan. It also advocates an increased awareness, critique, and practical adoption of ICD-11 in Pakistan to enhance the quality of mental health care and research.

KEYWORDS

Cultural Competency; International Classification of Diseases; Mental Disorders; Mental Health Services; Pakistan.

The diligent use of an international disease classification system by mental health institutions in Pakistan has become essential and is no longer a matter to be pondered over. The ICD-11 version is in the process of gradual adoption the world over. How 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, use in telepsychiatry, and Pakistan's standing in the international mental health community. The effective use of a classification system amidst the existing challenges requires an active critique, clearer understanding, and an incisive debate.

The canvas showing the mental health scene in Pakistan is a picture with several shades of greymuch 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, of course, 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 departments of Mental health, Psychiatry, Behavioural Sciences, and Institutes of Psychiatry.

Some districts, tehsil/taaluqa, or primary care centres have psychiatrists or trained primary health care physicians who are expected to provide drug-based interventions for patients with psychiatric disorders, broadly categorised as dementia, psychosis, anxiety, depression and drug abuse. The private sector has a similar range of conditions but with an immense Variation in the nature of facilities such as clinics and indoor units that provide expensive but scientifically run clinical care in aesthetic and relatively ethical practices and others that are shabby and pathetic indoor facilities 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 the public and private sectors are inundated by a large patient load. The outpatient clinics in teaching units in tertiary care facilities undertake the obvious route: the 'quick disposal of cases' through listening to symptoms and the prescription of psychotropics in most consultations lasting a few (3-5) minutes. This model finds some modification in private settings where a few clinicians take out time to dissect the symptoms to reach a clinical diagnosis and seek 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 bio-psychosocial model of care. Similarly, some public sector or teaching hospitals have developed psychometric laboratories, offer counselling and psychotherapeutic services after a diagnosis based on international classification systems (ICD and DSM), and adhere to the evidence-based practice of Psychiatry. Sadly, such institutions are very rare. The majority of private and public sector institutions do not use an international classification system at all, and their professionals have no or limited understanding of the use of an international disease 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, the World Health Organisation`s Provisional Committee was given the task of producing ICD-6. From then onwards, WHO has been producing ICD at intervals of 10 years. ICD-10 was published in 1992.[1] In an effort to bridge the gap between the ICD & Diagnostic & Statistical Manual (of Psychiatric Disorders), provide evidence for higher reliability and clinical utility, and form an AI Intelligence)-friendly classification system, the World Health Organisation 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 neuro-developmental disorders appear first, and neuro-cognitive 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 Kraepelinian approach after a century. Other distinguishing features of ICD-11 from its earlier version include digitalisation, a departure from the age-old 'Kraepelinian' dichotomy of 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 standout feature is the openness of the ICD-11 system in its capacity to be equally helpful 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 nosologies augurs well for mental health professionals around the world and can help them communicate more meaningfully.

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 diabetes and hypertension, eventually developing vascular dementia, and then a cerebrovascular 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 disorders. Additionally, ICD-11 has some major innovations, like the integration of a dimensional approach with a clear inclination towards a biological viewpoint in diagnosis. This may help in the common cause for destigmatisation 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 cumulative impact on function covered. In spite of these formidable numbers and complexities, ICD-11's online and offline versions ensure 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 was launched two years ago, but even in the NHS (UK), 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 the ICD-11 browser, coding tool, API, or application planning interface. Unlike ICD-10, there are no cutoffs. 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 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.[2] Similarly, health anxiety or hypochondriasis is now linked with obsessive compulsive disorders. Acute stress reaction is no longer a mental disorder.

Some newer categories included in ICD-11 are Complex Post-Traumatic Stress Disorder (PTSD), Prolonged Grief disorder, Catatonia, 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 longer a elevation myocardial infarction have significantly decreased separate category. Similarly, Persistent mood disorders, including cyclothymia, dysthymia, and Rett Syndrome, have been deleted from ICD-11. The lifespan approach adopted for ICD-11 meant that the separate grouping of behavioural and 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 categorised with Anxiety and stress-related disorders. The chapter on Drug Dependence has been expanded with the 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.[4] 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 considerable caution. Alongside the rest of their fraternity from low and middle-income countries (LMICs), 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, LMIC 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 to ICD-11.[5]

Hope and trepidation go hand in hand among mental health professionals in Pakistan in terms of ICD-11. Mental health professionals in Pakistan are concerned about the cultural sensitivity and appropriateness of this newer classification. The potential of overdiagnosis 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 organised in a conference at Rawalpindi, Pakistan. A keen interest was shown by the participants. Valuable inputs and critical discussion by the psychiatrists, trainee psychiatrists, and medical students in that session were very encouraging in terms of the attitude of mental health professionals towards understanding ICD-11.

There is a growing need for running seminars, discussion groups, and critique sessions for 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 mental health teaching facilities.

The provincial mental health authorities may also play their role in starting elaborate training and teaching sessions on ICD-11 across 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. Bartolomé JM, Sartorius N. Clasificacíon de las enfermedades mentales: de Bertillón a la CID-10, un siglo de colaboración internacional [Classification of mental diseases. From Bertillon to CID-10: a century of international collaboration]. Actas Luso Esp Neurol Psiquiatr Cienc Afines. 1994;22(5):193-199.
2. Reed GM, Drescher J, Krueger RB, et al. 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 [published correction appears in World Psychiatry. 2017 Jun;16(2):220. doi: 10.1002/wps.20433]. World Psychiatry. 2016;15(3):205-221. doi:10.1002/wps.20354
3. Bränström R, Pachankis JE. Country-level structural stigma, identity concealment, and day-to-day discrimination as determinants of transgender people's life satisfaction. Soc Psychiatry Psychiatr Epidemiol. 2021;56(9):1537-1545. doi:10.1007/s00127-021-02036-6
4. Reed GM, First MB, Kogan CS, et al. Innovations and changes in the ICD-11 classification of mental, behavioural and neurodevelopmental disorders. World Psychiatry. 2019;18(1):3-19. doi:10.1002/wps.20611
5. Khan MNS, Irshad M, Nasar A. Clinical Application of ICD-11 and its Understanding Among the Psychiatrists and Post Graduate Psychiatric Residents of Pakistan. J Pak Psychiatr Soc. 2022;19(03):8-10. doi: https://doi.org/10.63050/jpps.19.03.176