Opinion (F60 – 69)

- Change Nomenclature
  - F60.2 Dissocail personality disorder

  ⬇

  - Affectionless or Cold (Callous) personality disorder (F code) with adult antisocial behavior (Z code)

- Reconsider
  - F62.1 enduring personality change after psychiatric illness

Numbers of Patients in Each Diagnostic Category

Diagnosis	Number
F00 - 09	628
F10 - 19	185
F20 - 29	719
F30 - 39	2,546
F40 - 49	2,340
F50 - 59	603
F60 - 69	189
F70 - 79	34
F80 - 89	14
F90 - 99	41
G4	175
Unknown	429

Field testing the large groupings of the ICD revision in Japan and the Asian Pacific region

Toshimasa Maruta, Makio Iimori
Department of Psychiatry
Tokyo Medical University

The 4th Meeting of the International Advisory Group for the Revision of ICD-10 Mental and Behavioural Disorders
(1 December 2008, WHO)

Organizations in Japan to prepare for the field trials

The ICD-11 Committee

(of The Japanese Society for Psychiatry and Neurology)

- Formed December, 2006; has been meeting every 3-4 months
- Core members: 19 experts
- 10 subgroups, collaborating closely with the Japanese Society for Psychiatric Diagnoses

The research team for the ICD-11

(Funded by the Japanese Ministry of Health, Labor and Welfare)

- Experts' meetings
- A web site dedicated for gathering ideas and opinions
- Literature review

Gathering Ideas and Opinions from Relevant Fields: An example page from the website

ICD-11へ向けて

A sample page taken from the website.
For more information, go to www.icd11mental.com

3

Gathering Ideas and Opinions from Relevant Fields (continued)

Another sample page taken from the website.
For more information, go to www.icd11mental.com

4

Asian Pacific Network

Candidates to be included in the Asian Pacific Network include:

Prof. Sung Kil Min (Seoul, Korea)*
Prof. Hai-Gwo Hwu (Taipei, Taiwan)*
Prof . Kua Eee Heok (Singapore) *
Dr . Park John Ik (Seoul, Korea)
Prof. Y S Kim (Seoul, Korea)
Prof . Chao-Chicy Chen (Taipei, Taiwan)
Prof. Cris Chen (Taipei, Taiwan)
Prof . Pandu (Indonesia)
Prof . Lulu Ignacio (Philippines) and others

* Already contacted

Questions to be considered in regards with field trials

I personally feel that the following questions should be considered:

- How will the insurance system (esp. its coverage) affected by the revision?
- How will the changes impact related areas? (e.g. occupational, forensic, etc.)
- Will the adaptation of drugs be changed or not?
- Is there a possibility that diagnostic definitions will become broader?
- Is a general definition of PD needed? etc.

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
11 – 12 January 2007, Geneva, SWITZERLAND

Meeting Summary Report

The first meeting of the International Advisory Group for the Revision of ICD-10 Mental and Behavioural Disorders was held in Geneva during 11 – 12 January 2007. The Advisory Group has been constituted by WHO with the primary task of advising WHO in all steps leading to the revision of mental and behavioral disorders in ICD-10 in line with the overall revision process. The list of participants is given in the Annex.

This Summary Report provides a summary of the conclusions reached in the meeting.

1. Conflict of Interest Declaration

The Advisory Group affirmed the importance of WHO's policies related to conflict of interest and declaration of such interest and agreed that each member must consider carefully the implications of these policies and report any real, potential or apparent conflict of interest to WHO. Members also agreed to report any new interest that may arise during their membership on the Advisory Group.

With regard to members' involvement in the DSM revision process, the Advisory Group did not perceive this as a conflict of interest *per se*. However, the Advisory Group agreed that its members should provide information on their involvement in other relevant professional activities to WHO, including the development of DSM-V and other involvements with professional organizations that may influence or be perceived to influence their participation in the ICD revision process.

The Advisory Group agreed that no member will report the deliberations of the Advisory Group in publications or presentations without prior approval of the Chair. In addition, the Advisory Group affirmed that its members will not make public statements on the revision process in their capacity as the Advisory Group members or in situations in which their comments may be construed in this manner.

The Advisory Group recommended similar policies for members of any work groups that may be established for the revision of the ICD-10 mental and behavioural disorders classification.

2. WHO's Family of International Classifications and General Plans on the Development of ICD-11

The Advisory Group noted the necessity for and the benefits of the revision of the ICD-10 mental and behavioural disorders classification to be consistent with the revision of the overall ICD classification. In particular, this includes compatibility between the structure, content, and terminology of the chapter and developing ontological framework for the system.

At the same time, the Advisory Group cautioned against the possibility of embedding additional errors in the system through forcing an external structure onto the chapter. In

particular, it is important that any such structure not require that decision rules be more definitive than is warranted by the tentative nature of much of the existing knowledge in mental health.

3. Objectives and Uses of ICD Mental and Behavioural Disorders
The Advisory Group affirmed the five main functions of the ICD mental and behavioural disorders chapter as follows:

1) Use in clinical settings;
2) Use in research;
3) Use as a tool for teaching and training;
4) Use for public health purposes; and
5) Use for statistical reporting purposes.

The Advisory Group agreed that, based on WHO's constitution and charter, the relevance of the ICD Mental and Behavioural Disorders chapter to public health should be a particularly important guiding principal. The Advisory Group identified the primary public health purpose of ICD-11 as being to provide tools that assist in reducing disease burden. In mental health, this requires the promotion of population health and interventions to maintain mental health across the life span and across populations and settings. That is, ICD-11 should provide a basis for collective action to sustain population-wide health improvement.

The Advisory Group considered it essential that the revised ICD mental and behavioural disorders chapter be usable and useful for the identification and treatment of those individuals who have or are at risk for mental disorders by those health care workers who are most likely to encounter them. It must also be usable and useful for countries with limited resources in their efforts to assess and reduce the disease burden of mental disorders and improve the public mental health.

4. Definition of Mental Disorders within ICD-11
The Advisory Group agreed that providing a definition of mental and behavioural disorders as a part of the chapter is important. A definition provides the boundaries for what is being classified. The Advisory Group supported the use of the term disorder over the terms disease and syndrome for the entities described in the chapter.

The Advisory Group recommended against having functional impairment or disability as part of the inclusion criteria for any specific disorder. The Advisory Group suggested that a general comment be made as part of the introduction to the chapter that functional impairment and disability are associated with many of the diagnoses in the chapter and that such impairment is generally relatively non-specific with respect to diagnosis. The introduction should also provide definitions of functional impairment and disability that are consistent with the International Classification of Functioning, Disability and Health (ICF) and refer readers to the ICF for additional information on the classification of functional status.

The Advisory Group agreed that it may not be possible to make a statement about functional thresholds that would be applicable across the entire chapter. The Advisory Group recommended that any material deemed necessary about functional impairment and functional thresholds be included as part of the material generated for specific disorders or broader groups of disorders and that such material make use of the ICF framework. The Advisory Group also recognized that the construct of disability is culturally embedded and

the need to consider this as a part of any formulation.

5. Inclusion of Additional Information in ICD Mental and Behavioural Disorders
The Advisory Group considered that assessment and classification are distinct activities and that the focus of the ICD is on the classification of disorders and not the assessment of people, who are frequently characterized by multiple disorders and diverse needs. The ICD should focus on providing information relevant to the classification of disorders, including relevant lexical definitions. The Advisory Group did not believe that the diagnostic classification manual should function as a textbook or guide to patient assessment or provide information on the use of specific assessment methods, although it recognized the importance of such material in improving the quality of care and the impact of services for mental and behavioural disorders. The Advisory Group recommended against conceptualizing ICD mental and behavioural disorders classification as a multi-axial system.

The Advisory Group also recommended against incorporating additional information such as associated features and disorders, laboratory findings, physical examination, medical conditions, prevalence, course, familial patterns, etc. as a part of the diagnostic classification system, unless these are part of the diagnostic criteria.

6. Inclusion of Sub-Clinical Conditions, Risk Factors and Protective Factors
While understanding and agreeing with the need for ICD-11 chapter V to be useful for preventive efforts, the Advisory Group did not support the inclusion of sub-clinical conditions, risk factors, or protective factors in the revision of the mental and behavioural disorders chapter. The Advisory Group suggested that a chapter on risk factors and protective factors might be a worthwhile endeavour for the whole of ICD. The Advisory Group recommended that risk factors and protective factors for mental and behavioural disorders be considered as a part of that process, if it is undertaken.

7. Additional Versions of ICD-11 Mental and Behavioural Disorders
The Advisory Group recognized the need for several presentations of the ICD-11 mental and behavioural disorders classification. The Advisory Group endorsed the envisioned structure of the classification as nested or telescoping, with different versions of the classification—e.g., primary care, clinical use, research—representing different "views" of the core material. This implies that clinical, research, and primary care presentations will all be developed together as a part of the same process. The Advisory Group recognized that developing various presentations together is a complex task requiring collation of data from several sources and settings and that such a process will be resource-intensive and will likely require additional time.

8. Organization of Coordination Groups
The Advisory Group recommended that the following Coordinating Groups be established to assist the Advisory Group and WHO with the revision:

1. ICD-DSM Harmonization Coordinating Group
2. Global Scientific Participation Coordinating Group
3. Stakeholder Input and Participation Coordinating Group
4. Resource Mobilization Coordinating Group

The Advisory Group recommended that these Coordinating Groups be established by WHO in consultation with the Advisory Group Chair, including the development of specific Terms of Reference. The Advisory Group emphasized that these groups should not consist entirely

of classification experts, members of a single discipline, or representatives of developed English-speaking or Western countries. The Advisory Group envisioned that these Coordinating Groups would report to the Advisory Group and be assisted by WHO.

9. Working Papers

The Advisory Group requested that the WHO Secretariat develop more specific implementation plans and Terms of Reference for working papers on the following topics and commission them for possible presentation to the Advisory Group during its meeting in September 2007.

1. The use of mental disorder classification in primary care (by physicians and non-physicians)
2. Dimensionality in mental and behavioural disorders, including the issue of thresholds
3. A complete listing of the differences between ICD-10 and DSM-IV-TR related to diagnostic categories and criteria
4. The state of the scientific evidence regarding how the broad categories of mental disorders should be conceptualized as well as the likely clinical utility of these groupings.

10. Timelines

The Advisory Group agreed with the following tentative timelines that are consistent with the overall ICD-10 revision process:

- An alpha draft version of the ICD-11 mental and behavioural disorders chapter should be completed for review by the Advisory Group by the end of 2008.
- A broad and international review and comment process on the alpha draft should be conducted during 2009.
- Based on comments received, a beta draft should be prepared during 2010. Field testing of the beta draft should be conducted during 2011.
- Based on the results of field trials, a final proposed version should be prepared during 2012 and made available for public review.
- It is hoped that the full ICD-11 will be ready for approval by the World Health Assembly in 2014.

These timelines will be reviewed and revised as the work progresses.

ANNEX: Summary Report of the 1st Meeting of the International Advisory Group for the Revision of ICD-10 Mental and Behavioural Disorders

WORLD HEALTH ORGANIZATION

1st Meeting of the International Advisory Group for the Revision of ICD-10 Mental and Behavioural Disorders

11 - 12 January 2007 - Geneva, SWITZERLAND

Conference Room M105

LIST OF PARTICIPANTS

1. Dr Gavin Andrews, Clinical Research Unit for Anxiety Disorders, St. Vincent's Hospital, 299 Forbes Street, Darlinghurst, NSW 2010, Australia. Email: gavina@unsw.edu.au

2. Mr Rolf Blickle-Ritter, International Federation of Social Workers, Psychiatrizentrum Münsingen, Leitung Sozialdienst, 3110 Münsingen, Switzerland. Email: rolf.blickle@gef.be.ch

3. Dr Amy Coenen, Director, ICNP Programme, International Council of Nurses, University of Wisconsin - Milwaukee, College of Nursing, PO Box 413, Milwaukee WI 53201-0413, USA. Email: coenena@uwm.edu

4. Dr David Goldberg, Institute of Psychiatry, King's College, London, United Kingdom. Email: spjudpb@hotmail.com

5. Dr Oye Gureje, Department of Psychiatry, University College Hospital, PMB 5116 Ibadan, Nigeria. Email: gurejeo@skannet.com

6. Dr Steven Hyman (Chairman), Provost of Harvard University, Harvard University, Massachusett Hall, Cambridge, MA 02138, USA. Email: steven_hyman@harvard.edu

7. Dr Michael Klinkman, the Co-chair of the Wonca International Committee on Classification, Director of Primary Care Programs, University of Michigan Depression Center, 1500 E Medical Center Drive, F6321 MCHC Ann Arbor, MI 48109-0295, USA. Email: mklinkma@med.umich.edu

8. Dr Maria Elena Medina-Mora, Instituto Nacional de Psiquiatria Ramon de la Fuente, Calzada Mexico-Xochimilco, Col. San Lorenzo Huipulco, México, D.F. 14370, Mexico. Email: medinam@imp.edu.mx

9. Dr Juan Mezzich, President, World Psychiatric Association, International Center for Mental Health, Mount Sinai School of Medicine of New York University, Fifth Avenue & 100th Street, Box 1093 New York, NY 10029-6574, USA. Email: juanmezzich@aol.com

10. Dr Geoffrey M. Reed, International Union of Psychological Science, Glorieta de Bilbao, 5, 4° 428004 Madrid, Spain. Email: gmreed@mac.com

11. Dr Karen Ritchie, Directeur de Recherche, Institut National de la Santé et de la Recherche Médicale, E 361 Pathologies of the Nervous System Epidemiological and Clinical Research, Hôpital La Colombière, 34093 Montpellier Cedex 5, France. Email: ritchie@montp.inserm.fr

12. Dr Khaled Saeed, H. No: B-18, St: 02, Rawalpindi Medical College Staff Colony, Rawal Road, B-18, St. 02, Rawalpindi, Pakistan. Email: saeedsh1993@yahoo.co.uk

13. Dr Norman Sartorius, 14 chemin Colladon, 1209 Geneva, Switzerland. Email: sartorius@normansartorius.com

14. Dr R. Thara, Director, Schizophrenia Research Foundation (SCARF), R/7A, North Main Road, West Anna Nagar Extension, Chennai- 600 101, India. Email: scarf@vsnl.com

15. Dr Xin Yu, Director, Institute of Mental Health, Peking University, Huayuanbeilu 51, Haidian District, 100083, Beijing, China. Email: yuxin@bjmu.edu.cn

Observer:

16. Dr Christopher Chute, Chair, Revision Steering Group (ICD); Mayo Clinic College of Medicine, Rochester, Minnesota, USA. Email: chute@mayo.edu

WHO SECRETARIAT:

17. Dr José Bertolote, Management of Mental and Brain Disorders, Department of Mental Health and Substance Abuse, WHO. Email: bertolotej@who.int

18. Dr Somnath Chatterji, Country Health Information, Department of Measurement and Health Information Systems, WHO. Email: chatterjis@who.int

19. Dr Tarun Dua, Management of Mental and Brain Disorders, Department of Mental Health and Substance Abuse, WHO. Email: duat@who.int

20. Dr Vladimir Poznyak, Management of Substance Abuse, Department of Mental Health and Substance Abuse, WHO. Email: poznyakv@who.int

21. Dr Benedetto Saraceno, Director, Department of Mental Health and Substance Abuse, WHO. Email: saracenob@who.int

22. Dr Shekhar Saxena, Mental Health: Evidence and Research, Department of Mental Health and Substance Abuse, WHO. Email: saxenas@who.int

23. Dr Bedirhan Ustun, Classifications and Terminology, Department of Measurement and Health Information Systems, WHO. Email: ustunb@who.int

WHO 精神保健および薬物乱用部
第 1 回「ICD-10 精神および行動の障害」国際アドバイザリー・グループ会議

2007 年 1 月 11 から 12 日にかけて、ICD-10 精神および行動の障害の改訂に向けた国際アドバイザリー・グループのミーティングがジュネーヴで行われた。このグループは、ICD-10 の全面改訂にあたり、精神および行動の障害に関する改訂作業と他の方面で同時に進められる改訂作業とが調和することを目指し設立されたものである。参加者名簿は添付書類を参照。
この Summary Report は、ミーティングで合意が得られた点についてまとめたものである。

1. 利害の衝突が起こった場合の申告について

WHO における利害衝突及びその申告に関する方針の重要性が確認された。また、WHO が持つ方針の意図するところを確認し、また、メンバーは利害衝突が生じた場合、それが実際のものであっても予測・予想されるものであっても WHO に報告することが確認された。今後アドバイザリー・グループに席を置く間に新しく生じる可能性のある利害についても同様のこととする。

DSM 改訂にも関わるメンバーについてであるが、アドバイザリー・グループとしては、ICD 改訂との併行参加それ自体を問題視していない。しかしながら、DSM-V 作成を含め ICD 改訂作業に何らかの形で影響を及ぼすであろうと考えられるような領域において活動を行っているメンバーは、その旨を WHO に伝えることとする。

次に、アドバイザリー・グループにおける討議内容を座長の許可なく出版ないし発表することを禁ずることで同意が得られた。また、改訂過程について個々のメンバーがアドバイザリー・グループを代表するような発言ないしそのように解釈される恐れのある発言を控えることも確認された。

ICD-10 精神および行動の障害診断分類 に関して今後設立されるであろう他のグループにおいても、上記と同様な方針は有用であると思われる。

2. WHO 国際分類ファミリーと全般的計画

精神および行動の障害 と ICD 全体、双方の分類に関する改訂が互いに一致する必要性及び利便性が確認された。これは特に各章の構造、内容及び用語に関する一貫性、並びにシステム全体としての方向性の一貫性を指すものである。

しかし同時に、外枠を重要視するあまりにシステム上の欠陥が増長されることがないようアドバイザリー・グループは警告している。現時点でのメンタルヘルスに関する我々の知識はあくまでも仮定的であり限定されたものであることを鑑み、何らかの決定を下さなければいけない状況において内容の吟味でなく外枠が優先されるような事態は避けなければならない。

3.精神および行動の障害 の目的と利用

ICD 精神および行動の障害 の章の担う主な役割について、アドバイザリー・グループは以下五点を確認した。

1) 臨床における使用
2) 研究における使用
3) 教育及びトレーニングにおけるツールとしての使用
4) 公衆衛生のための使用
5) 統計を要するレポートに際する使用

WHO の Constitution と Charter に基づいて、改訂に際して ICD 精神および行動の障害 の公共衛生に対する関連性が特に重要な基本方針であるということでアドバイザリー・グループは合意した。また、ICD-11 の公共衛生に関する主たる目的として、疾病による負担を軽減するためのツールを提供することであることが挙げられた。メンタルヘルス領域においては、(疾患を抱えた特定の人々だけではなく）人口全体の健康の推進、つまり、すべての年齢、階層や種族、状況を想定したメンタルヘルス維持のための介入が必要となる。端的に言うならば、ICD-11 は全人口を対象とした健康向上を維持するための包括的な活動のベースを提供する、という役割を負う。

また ICD 精神および行動の障害 は、現場で実際に現在精神障害を持っているまたはそのリスクが高いと思われる人々に接することとなる者にとって、有用かつ有益でなければならないとアドバイザリー・グループは考える。また、特に精神障害の負担軽減および公共精神衛生の向上に際しての活用可能なリソースが限られている国々においても有用かつ有益であることが重要である。

4. ICD-11 における精神障害の定義

精神および行動の障害 そのものの定義を ICD の一部として含めるが重要であるとアドバイザリー・グループは判断した。精神および行動の障害 を定義づけることで、何がその分類の対象として扱われているのかが明確となる。また用語に関しては、疾患 (disease) や症候群 (syndrome) ではなく、障害 (disorder) を一貫して使用することで合意した。

機能障害 (functional impairment) や能力低下 (disability) に関しては、これらを障害 (disorder) の判断基準には含めない方針をアドバイザリー・グループは支持した。機能低下並びに能力低下は 精神および行動の障害 の章に含まれる診断名と関わりがあるケースが多い反面、診断名と直接的な因果関係にないことも多いことから、このことを章の冒頭で触れておくべきとの提案があった。また、機能障害と能力低下の定義を、国際機能分類 (International Classification of Functioning, Disability and Health, ICF) に沿ったかたちでふれること、また機能レベルに関するより詳細な情報については ICF を参照するよう促す旨を含めることで合意した。

章全体に適用可能な機能レベルに関する記述を導き出すことは、不可能かもしれないとの見解が出された。 したがって、機能レベルに関する記述が必要不可欠と思われる場合には、適用対象となる特定の障害ないし障害群を明記すること、それらの記述はあくまでも ICF に準ずるものとすることが提案された。最後に、どのような記述がなされるにしても、能力低下(disability)の概念はあくまでも文化的背景に根差したものであることを念頭に置く必要があることが確認された。

5. ICD 精神および行動の障害 への付加的情報の包含

アドバイザリー・グループは、アセスメントと分類は本質的に異なるものであり、また ICD の重点はあくまでも障害の分類であって個々の人間のアセスメントではないとの見解を示した。これは一個人であっても複数の障害に影響を受け得ること、また人間には多様なニーズがあることを考慮した結果である。よって、語彙的意味も含め障害の分類に関する情報を提供することが ICD の果たすべき役割である。また、アセスメントがサービスやケアの質に及ぼす影響は大きいことを認めた上で、あくまでも ICD は個々の患者のためのアセスメントに使用されるべきでないとの意見が出された。これは、ICD は個々の障害ないし診断名を明確にするためのものであり、個々の患者の複雑な病態を査定する際の教科書やガイド的なものではなく、またアセスメントの際に使用される特定の査定法に言及するものでもないからである。また、ICD の分類を多軸システムとみなすことに関しても、アドバイザリー・グループとしては反対する意思を示した。

付加的な情報ではあるが診断分類システムへ盛り込むことが見送られたのは、特定の障害に関連のある特徴や他の障害、検査所見、身体的な検査、医学的状態、有病率、経過、家庭的パターンなどである。これらは診断基準でない限り、各障害の記述には含まれない。

6.臨床域値下、危険因子および保護的因子の包含

アドバイザリー・グループは ICD-11 第五章が予防的措置に有用であるべき必要性を認めたが、最終的に sub-clinical conditions, risk factors and protective factors を精神および行動の障害 の章に含むことにを支持しなかった。しかし同時に、ICD 全体で risk factor と protective factor に関する章を扱うことには前向きであり、精神および行動の障害 に関する risk factor と protective factor の記述も、予防的措置を検討する他の独立した章で扱われるのであれば問題ないとの見解を示した。

7.精神および行動の障害 の複数のバージョン

ICD-11 精神および行動の障害の分類に関して、核をなす部分は一貫性を保ちつつ、その表現方法については用途や場面に応じて何通りかの異なるバージョンが必要ではないかとの意見が出された。ICD 使用の用途が異なる(したがって異なる Presentation が必要となる)かもしれな

い場面としては、Primary care、臨床、研究が例として挙げられた。これら三つの状況を想定したバージョンは、ICD-11 作成というひとつのプロセスのもと、すべて同時進行で作成されることとなる。異なるバージョンを同時に進めるというのは、様々なソースからの情報を要する非常に困難な作業であり、またより多くのリソースおよび時間が必要となるであろうことが想定される。

8. コーディネーティング・グループの設立

ICD 改訂に向けてアドバイザリー・グループならびに WHO の補佐的役割を果たすグループとして、以下の Coordinating Groups を設立することが提案された。

1. ICD-DSM Harmonization Coordinating Group
2. Global Scientific Participation Coordinating Group
3. Stakeholder Input and Participation Coordinating Group
4. Resource Mobilization Coordinating Group

これらの Coordinating Groups はアドバイザリー・グループの座長との協議の上 WHO によって設立されるものであり、具体的な委託事項も決定される。これら Coordinating Groups には多様性が重要であり、分類の専門家のみ、特定の分野からのメンバーのみ、あるいは西欧の先進国からの代表のみといった偏った編成にならないよう留意すべきとの点があらためて強調された。これら Coordinating Groups はアドバイザリー・グループへの報告を行い、WHO の援助を受けるものである。

9. ワーキング・ペーパー

アドバイザリー・グループは、以下の項目に関する論文のより具体的な計画と委託事項の立案をまとめるよう WHO 事務局に依頼する旨を決定した。これは、2007 年 9 月に行われるアドバイザリー・グループミーティングでの発表を視野に入れたものである。

1. プライマリ・ケアにおける精神障害分類の利用状況（医師、非医師による）
2. 精神および行動障害の多次元性（Dimentionality）、閾値（Threshold）の問題を含む
3. ICD-10 と DSM-IV-TR の診断分類および基準をめぐる相違点の総括
4. 現在の科学的根拠に照らし合わせた精神障害の分類のあるべき姿、およびその分類の臨床における有用性

10. タイムライン

ICD-10 全体の改訂過程に合わせ、以下のタイムラインが暫定的に設定された。

- 2008 年末までに ICD-11 精神および行動の障害 アルファ草案版の完成、その後アドバイ

ザリー・グループによるレビュー

- 2009 年内に上記アルファ草案版に対する意見を各国から収集
- 2010 年内にアルファ草案版に寄せられた意見をもとにベータ版を作成
- 2011 年内にベータ版に関するフィールド・テストを遂行
- 2012 年内にフィールド・トライアルの結果に基づき最終版の作成、一般公開
- 2014 年、世界保健総会による ICD-11 の完成版承認を目指す

これらはあくまでも暫定的なものであり、進行状況に応じ順次変更もあり得る。

訳
東京医科大学精神医学講座
松本ちひろ、丸田敏雅、飯森眞喜雄

参考資料 5

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 bahavioral 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

LIST OF PARTICIPANTS

1. Gavin Andrews, Clinical Research Unit for Anxiety Disorders, St. Vincent's Hospital, 299 Forbes Street, Darlinghurst, NSW 2010, Australia. Email: gavina@unsw.edu.au

2. Rolf Blickle-Ritter, International Federation of Social Workers, Psychiatrizentrum Münsingen, Leitung Sozialdienst, 3110 Münsingen, Switzerland. Email: rolf.blickle@gef.be.ch

3. Amy Coenen, International Council of Nurses, University of Wisconsin - Milwaukee, College of Nursing, PO Box 413, Milwaukee WI 53201-0413, USA. Email: coenena@uwm.edu

4. David Goldberg, Institute of Psychiatry, King's College, London, United Kingdom. Email: davidpgoldberg@yahoo.com

5. Oye Gureje, Department of Psychiatry, University College Hospital, PMB 5116 Ibadan, Nigeria. Email: gurejeo@skannet.com

6. Steven Hyman (Chairman), Harvard University, Massachusetts Hall, Cambridge, MA 02138, USA. Email: steven_hyman@harvard.edu

7. Michael Klinkman, The World Organisation of Family Doctors (Wonca), University of Michigan Depression Center, 1500 E Medical Center Drive, F6321 MCHC Ann Arbor, MI 48109-0295, USA. Email: mklinkma@med.umich.edu

8. Maria Elena Medina-Mora, Instituto Nacional de Psiquiatria Ramon de la Fuente, Calzada Mexico-Xochimilco, Col. San Lorenzo Huipulco, México, D.F. 14370, Mexico. Email: medinam@imp.edu.mx

9. Juan Mezzich, World Psychiatric Association, International Center for Mental Health, Mount Sinai School of Medicine of New York University, Fifth Avenue & 100th Street, Box 1093 New York, NY 10029-6574, USA. Email: juanmezzich@aol.com

10. Geoffrey Reed, International Union of Psychological Science, Glorieta de Bilbao, 5, 4° 428004 Madrid, Spain. Email: gmreed@mac.com

11. Karen Ritchie, Institut National de la Santé et de la Recherche Médicale, E 361 Pathologies of the Nervous System Epidemiological and Clinical Research, Hôpital La Colombière, 34093 Montpellier Cedex 5, France. Email: ritchie@montp.inserm.fr

12. Khaled Saeed, H. No: B-18, St: 02, Rawalpindi Medical College Staff Colony, Rawal Road, B-18, St. 02, Rawalpindi, Pakistan. Email: saeedsh1993@yahoo.co.uk

13. Norman Sartorius, 14 chemin Colladon, 1209 Geneva, Switzerland. Email: sartorius@normansartorius.com