



The 27th Congress of the World Federation for Mental Health

February 2003

A Report
by

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1. Background

The Writers - Acknowledgements

Robin Hanau is a mental health service user. He has attended the congresses of the WFMH for several years now, funded by CNWL Mental Health NHS Trust.

Rogan Wolf is support worker to the Westminster user groups. Robin usually goes to these conferences alone, but this time Rogan went too - for the specific purpose of doing a presentation with Robin of the ward round code. This code, now policy at CNWL, was originally put together by local user groups. Earlier in 2003 it was recognised officially by the Department of Health as "good practice" (see below). Several months before the WFMH Congress, the conference organisers had agreed that we should present the code there.

Acknowledgments and thanks should be given to the Trust for again funding Robin's fares, conference registration and accommodation.

The Westminster user groups funded Rogan's expenses and thanks should be given to them too. But further thanks to the Trust are due for helping the pair organise their trip as a joint enterprise— booking the air tickets, the hotel and so on.

The World Federation - What is it ?

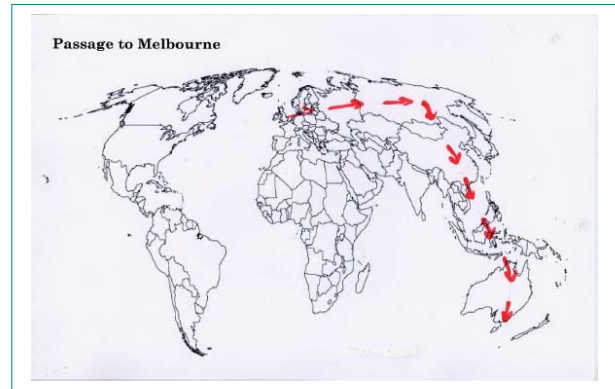
The World Federation for Mental Health was founded in 1948. It describes itself as "the only worldwide, multi disciplinary, grassroots advocacy and public education organisation concerned with all aspects of mental health. We are an international body of organisations and individuals that work to promote, among all people and nations, the highest possible level of mental health in its broadest biological, medical, educational and social aspects." Based in the United States, the Federation holds a major conference every two years, each time in a different country. This year was the turn of Melbourne, Australia.

Delegates vary, of course, but include a significant proportion of psychiatrists and senior figures from the various countries' mental health services. There is an occasional politician. The user movement is represented there in increasing strength as congress follows congress.

Speakers also vary greatly but include some distinguished international figures not just from the mental health world, but from the World Health Organisation, the Trade Union Movement, the Academic world, etc.

Melbourne

The journey went smoothly, though was horrendously long - virtually a full day. Anyone who hasn't travelled much should take it from us that travel is not movement at all but endless sitting - in tube, in airport, in plane, in bus, in plane again.... The traveller sits for hour after hour while the world changes outside the window.



Melbourne is a beautiful city, on the south west tip of Australia. It is built along the Yarra River, an important part of its life and character. The city centre offers a dramatic and exuberant skyline, like a newer and in many ways more beautiful Manhattan.



The streets tend to be wide and the transport system includes tram routes down the centre of each street. Many of the trams have an old-fashioned look, similar to the traditional San Francisco trams. All in all, it's an exciting mixture.

The cost of living seemed less expensive than in this country and there was obviously a strong tradition of eating out,

many of the restaurants being situated overlooking the Yarra.

Down each bank were wide and popular walk-ways - which the population used almost like pathways in a park - to jog, cycle, walk and court. So every evening the riverbanks were crowded with people and the atmosphere was vibrant - and pleasantly distant from traffic. In some ways, as London has Hyde Park, Melbourne has the banks of the Yarra.

The restaurant food tended to be excellent and often combined ethnic traditions and styles into something new and exciting.

The population too was extremely multi-cultural and people seemed confident and at ease. There seemed less of a social hierarchy than here in England, at least at first sight. Builders looked you in the eye and with pride and greeted you with genuine friendliness. Waiters and waitresses seemed proud of the food they offered you and of the jobs they did.



We stayed in a hotel on the South Bank and walked each day along the river to the World Trade Centre where the congress took place.

How the Writers Worked Together

On our arrival at Melbourne, we emerged in a dazed and fractious state and Rogan promptly left his hand luggage behind at one of the air-port barriers. The luggage contained money, passport and lap-top computer. Luckily one of the air-port staff had noticed and put it by and Security returned it quickly. This sort of thing was familiar to them, they said. People's first experience of Australia was often a frantic air-port search for something lost.

We arrived on the Wednesday morning. The weather was warm and a bit drizzly. We learnt later that this was very significant. It meant a long draught had just broken, though not completely, as the weather was lovely again towards the end of our week there.

The conference started on the Thursday afternoon. Robin concentrated on attending the conference programme in its entirety, as usual ; Rogan, whose purpose in attending was slightly different, attended the majority of the presentations but also took time out, a/ to prepare our own presentation and b/ to network with different individuals with a view to disseminating the code as widely as possible.

The conference followed the common pattern of plenaries and workshops. For some of the workshop sessions we split up but decided this need not be a rule. We met for breakfast each morning and conferred frequently during each conference day. In the early evenings we met again to de-brief and transfer notes onto the computer.

Following our return from Melbourne, we met four or five times through the Spring and early Summer of 2003, turning the notes into a report. Our last meetings were to decide the editing of our presentation.

The Ward Round Code : Background

The code was originally put together by the Westminster

Excerpts from the Ward Round Code

1. Before the Meeting

It should be made clear that a service user's attendance at a ward round or CPA is voluntary. Service users may choose instead to meet one of the professionals involved in the team, either beforehand or afterwards.

2. People Present

The number of professionals present should be kept to a strict minimum - say, three or four.

Students should attend the ward round only with the service user's permission.

Should a service user wish to bring a family member, friend or an advocate to the meeting, this must be encouraged.

3. Questions

The service user's mental or emotional state should not be insensitively examined in public and amongst strangers with tests or questions which lower his/her dignity.

User groups, supported by Rogan. Individuals used their own experiences of ward rounds to compose a list of how these and similar meetings could be made less intimidating and more respectful of the individual at the heart of them. (Above are some points made by the code. It can be read in full in Appendix Three of this report)

The code was published by *OpenMind* in 1997. It became CNWL Trust policy in 2000.

In November 2002, the Westminster User Groups presented the code to the All-

Department of Health Response 30 April 03

“Thank you for your letter of 11 February to Jacqui Smith, Minister of State, about codes of conduct in mental health. I have been asked to reply...

I am pleased that the code you enclosed with your letter which the Westminster groups have produced is working well and has been adopted as policy by CNWL Mental Health NHS Trust.

...The Department of Health does..welcome such initiatives..., and [it] is an example of good practice it would want to support...

...We would...want to use the strong development channels within mental health to spread these ideas...so thought can be given about how the structure for NIMHE can support these proposals. NIMHE will also look at how it can use its network of development centres across England to share the concepts too...”

Yours sincerely

Party Parliamentary Group for mental health in Portcullis House, Houses of Parliament, where support was given to the suggestion that this was a standard that applies nationally. The code has since received recognition from the Department of Health and help has been offered to promulgate its ideas across the NIMHE Local Development Groups. On the left are some excerpts from the D. of H. letter we received.

Our largest hope in making the presentation to the WFMH was that the code could become an *international* standard as well ; our smallest, that we would simply spread the idea of it to a few more people.

We made our presentation as one of several others, during the afternoon of the third day,

to a small audience dotted about a large hall. We shall report on the presentation in more detail later in this report.

2. The Conference

General Observations

It became apparent very quickly that we had travelled across the world to meet in Australia approaches and strategies for improving mental health very similar to those now familiar in the UK. Furthermore equally similar strategies had been put together by several other countries. The National Service Framework would appear to be an *International* Service Framework.

All the countries from the developed world seemed to have reached similar conclusions and to be following the same priorities, with the same main headings, even the same jargon - crisis resolution, assertive outreach, suicide rates, user and carer consultation, partnership, evaluation, etc.

In contrast, delegates from the developing world spoke of completely different issues – mainly the fact that in some countries there are simply no mental health services at all. The issue for them (apart from gross shortage of specialist expertise and resources) is therefore, how best to support and educate the families in which mental illness occurs and lessen the sense of stigma and shame that still predominates.

Also, from time to time, we learned in Australia of initiatives in the UK that were completely new to us. Which suggests that long-distance travel is a good way to get acquainted with your own country !

It also suggests how muffled is the voice of New Labour in speaking of its positive work and real progress and how deeply inter-woven all countries are now, in their search for solutions to common problems.

On the other hand we did meet with several very good ideas, good examples of innovative good practice under one or other of these internationally accepted main headings. Given the international culture of information-share mentioned above, these examples are probably familiar to some people in this country. But is the practice familiar to *everyone* whose work would benefit from knowing about it ? And are those people all going to be in the audience of a single presentation ? (this paper was presented at CNWL head office in December 2003). We think not and we shall be asking for advice and ideas on how else to disseminate the ideas and initiatives we learned about in Melbourne.

Finally, though, a striking lesson of the conference was how limited is the usual scope and remit of the specialist mental health services, largely just reacting as they must to the needs of individuals for whom things have already gone wrong. The conference kept putting mental health and mental ill-health into a larger frame, suggesting that Societies will only improve the mental health of their citizens when they succeed in making a whole way of life more conducive to good mental health. And this requires urgent action from all sides and levels of Society, working in partnership. The specialist services can only be a part of the solution. In a sense, however, this can be a relief to those involved. As the specialist services need to work with all elements of Society to improve mental health, so they don't have to feel entirely responsible when things go wrong.

Day One : Thursday pm 20th February.

The conference began with an afternoon session which acted as the opening ceremony and included a few welcoming speeches, followed by some dancing by a small group of traditionally dressed middle-aged Aborigines, obviously used to this kind of occasion. An urban lecture hall did not do them justice but they danced well and accepted our applause patiently.

Day Two : Friday

User welcome

This took place before the first plenary.

In total about 20 people were there, chaired by Dr Sylvia Caras, a user and member of the WFMH Board. Dr Burrows, the Conference Chair, had been criticised for excessive use of the drugs approach, she said. The group were also uneasy about another speaker due to appear on the first day, Rev Hollingworth, criticised in public for his defence of a sex abuser.

Sylvia reported that the Board had not adopted some of the user resolutions opposing enforced treatments and ECT.

Users introduced themselves to each other and Robin mentioned the ward round code presentation and asked everyone else to come.

Opening Addresses.

There were five speakers at the opening session.

First Speaker : Prof Graham Burrows, Chair of the Congress

Prof Burrows told us that the 500 delegates present today included representatives from 40 different countries. Less delegates had arrived than had booked – due probably to post-September 11th fears.

Second Speaker : The Rt Rev Dr Hollingworth Gov General of Commonwealth of Australia

He said that for the past 20 years Australia had pioneered policies to prevent mental illness.

He compared present conditions with those of 1975, which was the last time that a Congress was held in Australia. There was no national mental health strategy then ; the main priorities and concerns were moving people and services away from reliance on the big institutions and finding and resourcing alternatives in the community ; medication, especially some of the major anti-depressants were still not available.

Now, rising costs and expectations put pressure on the systems. He added an example topical in Australia during the time the Congress took place - a long-standing draught - and how a crisis of this kind can have all sorts of ramifications, including mental health ones.

He suggested that solutions to specific mental health problems are often at the same time solutions to general social problems. Child abuse is an example. Improved mental health means a better quality of life for the whole of Society.

He made the common point about the need to address stigma and also referred to an Australian problem (also a problem in Canada where Robin was 2 years ago) - the difficulty of providing services in remote areas.

Third Speaker : The Hon. Bronwyn Pike. Minister of Health for State of Victoria

She said that Australia is a land of new arrivals, a land of visitors.

She listed the 6 points in their mental health strategy –

getting the overall picture right - an appropriate balance between in-patient services and community services and other fields such as adolescent services ;

service priorities and options to be better targeted and to relate to real needs and the real environment, environment to be genuinely therapeutic, there needs to be better after-hours access, and a system better able to sustain people, rather than just respond episodically and departmentally

Keep emphasising preventative work and policies

employment in mental health

consumer participation - to keep focus on human rights, as well as counter-act the bureaucrat's tendency to act in a closed way

carers participation

Fourth Speaker : Senator Kay Patterson - Minister for Health and Aging for the Commonwealth of Australia.

She mentioned Australia's initiatives in Tele-Psychiatry – a video link. Every 5th visit should be face to face.

She highlighted a primary care training programme that took place in 2000 to ensure GP's are given training in mental health and involved in planning and reviews of mental health patients. Training was also offered to GP's in Cognitive Therapies.

She described "Mind Matters" – a promotional programme to offer teachers training in mental health to help them deal with situations in the school that have a mental health component.

Mental Health Strategy, Victoria

- **getting the overall picture right - an appropriate balance between in-patient and community services**
- **services should be targeted on real needs, ie the care environment should be genuinely therapeutic, with better after-hours access ; the system should aim to sustain people, rather than just respond episodically and departmentally**
- **Emphasise preventative work and policies**
- **Prioritise employment strategies**
- **consumer (user) participation - to keep focus on human rights, as well as counter-act the bureaucrat's tendency to act in a closed way**
- **carer participation**

The Australian “Mind Matters” Initiative

A promotional programme to train school teachers in mental health.

17,000 staff in Australia had been trained.

The programme had reached 65% of Australia’s 32,000 secondary schools.

It was not imposed on teachers –

- **they were asked what they wanted**
- **the idea was pilot tested**
- **the scheme was made part of teachers’ career development**

ie teachers had a real incentive for undertaking the training.

Scheme required close partnership between Govt Depts at highest level and an over-arching vision of Society’s mental health needs.

So far 17,000 staff had been trained. The programme had reached 65% of Australia’s 32000 secondary schools. (This was an example of an initiative that could not have begun without partnership at the highest level between one department (Education) and another (Health) ; and in its details and thoroughness of approach seemed an excellent initiative. See Appendix One of this report for more details.

The Senator described the care with which the initiative was carried out – it was a proper process. For instance teachers were asked what they wanted, pilot tested the idea, and the whole scheme

made very much part of teachers’ career development, ie it offered a real incentive for the teachers, rather than merely imposed something on them.

The idea has already been adopted in Germany. Is it relevant to Britain ? If so, why has it not been tried here ?

Senator Patterson went onto “Mind Matters Plus” – an extra training package for helpers/teachers who teach pupils with a high level of mental ill-health needs or problems.

Then she talked of “Mind Frame” – an initiative that sought to give a role to the media in improving mental health, rather than too often just reflecting the usual prejudices. Mental health training was offered to media, eg in how to report suicides in a way that did not encourage copycat suicides.

Again, has this idea been pursued in Britain ? It could be adopted at local level no less than at national level.

Fifth and Last Speaker in this session : Ms Pirkko Lahti, President of the World Federation

She described the role, range and achievements of the WFMH

She told us that World Mental Health Day is a WFMH creation. This is one of several ways the organisation tries to raise the profile of mental health issues, and raise service standards, across the world.

She said that the bi-annual congress that we were attending here in Melbourne was another way

Day Three : Saturday

Am. Plenaries

Speaker : Dr Shekhar Saxena, World Health Organisation (WHO)

He gave a presentation of the Mental Health situation in the World, as WHO now measures it. He described what WHO calls its “Global Action Programme”.

He began with a principle basic to WHO’s activities and approach : “ The *Burden* of Disorder is caused by mental disorders and not by *people* with mental disorders.”

He described a measure called DALY – “Disability and Adjusted Life Years Lost” (world wide).

(It means premature mortality and years of productive life lost due to disability). He compared some dates, with figures for the DALY.

1900	10.5 %
2000	12.3%
2001	13.0%
2002	15.0% (est.)

In other words, the world-wide burden of mental ill-health is constantly increasing.

On a simpler scale YLD - ie (premature death) mental health as a burden ranked even higher.

On a scale of killers, such as road accidents, TB, AIDs etc, depression was near the top of the list at 12%.

The Economic impact of mental Ill-Health

USA \$148 billion = 2.5 % of gross national product.

World Wide Statistics on Mental Health

“Disability and Adjusted Life Years Lost” - DALY

<u>Date</u>	<u>DALY</u>
1900	10.5 %
2000	12.3%
2001	13.0%
2020	15.0% est

ie the world-wide burden of mental ill-health is constantly increasing.

As a Cause of Premature Death
Depression’s near the top of list at 12% cf. road accidents, TB, AIDs etc

The Economic impact of mental Ill-Health

UK spends 22% of its healthcare revenue on mental health. Netherlands spends 23%.

Burden of caring – mental ill-health affects life quality and physical health not just of individuals but their families who help care for them.

UK mental health expenditure 22% of all health service costs
Netherlands 23%

He mentioned another burden - The Burden of caring_– it takes toll on life quality and physical health - affecting whole family.

Resources Available

Dr Saxena gave the website address of WHO's breakdown of the mental health resources available in each continent/country of the world

For the address see Appendix Five.

Or one can look for it in Google under "mental health atlas"

The atlas gives 2 or 3 pages on resources available in each WHO affiliated country.

Mental Health Resources – Comparisons World-wide

In the 3rd world there are very few psychiatrists. Africa and South E Asia have a relatively minute number.

Eg In Angola there's no govt funding for mental health and no psychiatrists

World-wide State Benefits for people with mental health problems vary greatly.

Africa is lowest, critically. Several countries have none, which means families pay until money runs out.

Poorest countries also spend the smallest proportion of their GNP on mental health, ie virtually none.

Poorest countries have the least services, relying most on families.

Conclusion : There is a massive disproportion between the burden of mental ill-health and the resources needed to meet it.

Eg The Atlas shows that Angola has no psychiatrists at all. In Angola there is no govt. funding for mental health.

State Benefits for people with mental health problems vary greatly. Africa is lowest - critically. Several countries besides Angola have none, which means families pay until money runs out. Dr Saxena pointed out that this is inevitably discriminatory.

Poorest countries also spend the smallest proportion of their GNP on mental health, ie virtually none.

Poorest countries have the least services,

Across the whole of the 3rd world there are very few psychiatrists. Africa and South E Asia have a relatively minute number.

Conclusion : There is a massive disproportion between the burden of mental ill-health and the resources needed to meet it. WHO made a

decision they cannot tolerate this and need to take action.

They therefore produced an Action plan on Mental health which resulted in :

- World Mental Health Day 2001 – a competition for children - huge numbers involved.
- Geneva - Call to Action for mental health ministers
- World Health Rept.2001 launched in Australia, which made 10 recommendations and proposed 4 core strategies :

Info for better decisions
 Integrated policy and service development
 Advocacy against stigma and discrimination
 Enhanced Research Capacity

(This last recommended that countries should do their own local research since you can't transplant policies from 1 country to another)

WHO also concluded that the WHO organisation itself needs to get better at working in partnership. It is based in Geneva, which is only one small place in the world. It has therefore decided to institute :

- Partnership with Govts
- Partnership with NGO's (annual convention)
- Mental Health Global Parliament planned for 2004 (members of various parliaments)

Speaker : H Herrman : Mental Health And Mental health promotion in Western Pacific

She said there 1.7 billion people in the region. It's an aging population. It ranges from the affluence of Japan to the poverty of Cambodia.

Effective treatments are available for some mental health and physical conditions, but a major problem in this region is that many people don't have access to those treatments for a whole variety of reasons including the concentration of resources in hospitals, which are hard to get to and perhaps off-putting.

The speaker provided the following definition : "Good mental health is the ability to think and learn and the ability to live with one's own emotions and the reactions of others." It is a state of balance and is inseparable from physical health. Mental health is more than the absence of disease. The social economic environment affects mental health. This is where Govts can help.

She went through the region's mental health strategy. The list was familiar, yet with one or two interesting angles -

1. Advocacy (to govts and general public)
2. Treatment services
3. Mental Health Promotion
4. Policy and Legislation
5. Research and Evaluation
6. Suicide Prevention

1. Advocacy. All countries can start a strategy, even the poorest. Families are the key-stone. So families need moral support and education as well as resources.

2. Treatment Services De-institutionalisation. Integration with general health care

3. Mental Health Promotion Decisions in education welfare, housing, employment and health sectors influence mental health.

4. Policy and Legislation national policies. Include guidelines and also the monitoring of standards of care

5. Research and Evaluation Scientific evidence produced locally has more influence on and meaning for people than evidence from outside.

6. Suicide prevention Draws on all five of above.

A Definition of Good Mental Health

Good mental health is the ability to think and learn and the ability to live with one's own emotions and the reactions of others.

It is a state of balance and is inseparable from physical health.

Mental health is more than the absence of disease.

It includes a spectrum of elements, such as supportive environments, meaningful activity, binding communities, etc.

The determinants of good mental health include –

- **social connectedness**
- **freedom from discrimination**
- **economic participation.**

A regional strategy for Mental Health Promotion would need to address all aspects of this spectrum.

The speaker talked about mental health promotion in the Western Pacific region as well, which includes widely divergent states and cultures, as well as major differences in affluence and development, eg Japan as compared to Samoa and Cambodia.

The strategy includes some exciting initiatives, plus an achievement in partnership that required organisational alliances at high level, plus extensive ground level community involvement

The speaker developed further the definition of mental health used by the project group. They concluded that good mental health includes a spectrum, such as supportive environments, meaningful activity, binding communities, etc. Determinants of mental health were seen as being - for instance - social connectedness, freedom from discrimination, economic participation. A regional strategy for Mental Health Promotion would need to address all aspects of this spectrum.

The process in Victoria was as follows :

Representatives were identified from over 1000 organisations from many sectors of the community.

5 population task groups were established, on a regional basis, and each advised on the initiatives being considered.

A conclusion that stood out from the groups was that mental health is strongly supported by “confiding relationships”

A general conclusion drawn from the strategy was that mental health is everyone’s business ; therefore there is a need for alliances. We need to do business with one another.

George Albee Lecture

Speaker : B Raphael The nature of Violence and Prevention

Origins of Violence

B Raphael is a respected Australian researcher and campaigner.

She said the Media is still quick to attribute violence to mental ill-health, despite the evidence that the link is unjustified.

Violence and Mental Health – Research Findings

Contributory factors to violence in Society - NOT mental health but :

- **Inequity - poverty, indignity,
marginalisation**
- **Family violence**
- **Schools as violent places**
- **Neighbourhoods of violence**
- **Violence in the media**

**1000 studies agree that media
violence leads to increased
aggression.**

**ie “social and psychological
distancing”**

However, she acknowledged a real risk associated with dual-diagnosis or co-morbidity, and with the diagnosis of Personality Disorder.

She said that research findings suggest that contributory factors to violence in Society are not mental health at all, but :

- inequity - poverty, indignity,
marginalisation
- Family violence
- Schools as violent places
- Neighbourhoods of violence
- Violence in the media

1000 studies all agree that media violence leads to increased aggression. She referred to “social and psychological distancing”

And yet she suggested there is a fascination with violence, otherwise why would the media feed us with it for their profit -”The dark beauty of violence,” she called it.

The speaker identified violence as a public health issue and emphasised the need for the continued development of, and training in, conflict resolution skills.

PM Workshops

Session on Legal Advocacy

Speaker : Sylvia Caras - UN Convention on Human Rights and Disability

Sylvia identifies herself as a user and runs an organisation called “People Who,” a worldwide network of users and survivors. (See Appendix Five)

She lives and works in California.

She spoke from her position of user on the Board of the WFMH. She also has been involved in United Nations committee work, representing the mental health service consumer movement with regard to Human Rights resolutions.

She stood herself for the following :

- the right to refuse treatment
- people with mental problems need to be recognised as experts themselves
- the slogan “Nothing about me without me”
- All people can have lives of quality (with reasonable accommodation)

She mentioned the traumatising of psychiatry that is still the experience of many people, so that the terror and degradation of treatment can outweigh the trauma of disturbance that preceded it.

She said that the Federation has a presence at the UN, and she would continue to campaign for and facilitate the inclusion in that presence of the user voice.

She was fascinated by the language of mental health - how it reveals and shapes attitudes. She believed that shifting the language can help to shift prejudice and behaviour.

On the subject of language, Sylvia Caras proposed the strategy now common among consumer pressure groups that the user movement must work to win acceptance for the notion that mental ill-health is a Disability, which qualifies for all the rights and standards now associated with the term. The thinking around this sees Disability as being part of a social model rather than a medical one. She suggested, for instance, that users can see themselves, not as disabled as such, but “differently abled”

Speaker : N Barber from Australia - a lawyer
Review of Civil Commitment - tensions in law and practice

The speaker made the point that mental health and ill-health constitutes a field of great flux and uncertainty ; while the law is built on a pattern of certainties and clear fixities. Perhaps the relationship between the two can never be other than unsatisfactory and the law will always find itself being sidetracked when it is applied to mental health issues.

He suggested that review bodies have a role but do not constitute a panacea. There is a need to give energy to improving the whole system, rather than just tinker with certain aspects of the law. For the law is tangible and can't be looked to to deal adequately with a subject so complex and *intangible* as mental ill-health.

He suggested that more law won't work. Review bodies will always tend to endorse the law that already exists. All the different mental health acts, including the UK one, seem to tend to the same result. A lawyer's field day.

Speaker M Bras : Informed Consent in the Treatment of People with Mental Illness

The speaker is a young psychiatrist from Croatia, creating a quality local mental health service in a state still emerging from civil war and still without the old infrastructures. For her it was a matter of asserting important basic principles, in a part of the world still emerging from chaos, in which rights of all kinds were ignored and degraded.

She said that in matters of consent, partnership has replaced the old paternalistic doctor/patient relationship.

Patients should be at the centre of all treatment even when treatment is being forced on them.

Partnership has replaced the old paternalistic doctor/patient relationship.

Patients should be at the centre of all treatment even when treatment is being forced on them.

“Informed consent is an important factor in the creation of a partnership model between patient and psychiatrist. The patient is not any more an object, but the subject and partner in all phases of diagnostic and therapeutic process.”

Every effort should be made to help the patient make a considered decision. Information should be given in a way that can be understood, all possible help given to ensure the patient can make sense of it, to maximise opportunity for voluntary consent.

Her conclusion : “Informed consent is an important factor in the creation of a partnership model between patient and psychiatrist. The patient is not any more an object, but the subject and partner in all phases of diagnostic and therapeutic process. In the creation of such a new model of partnership, education of professionals and the public is the most important issue.”

Comparison of Involuntary Detention provision

While countries legislation is basically similar, so also there are important differences

eg The Australian law : “the best care and treatment with least restriction”

Public nuisance and Self neglect is a criterion for involuntary detention in The Netherlands and Australia

Where treatment is a requirement in one of the sections of English law, it does not appear in the Dutch equivalent.

Speaker : Pirkko Lahti : The Link between Health and Culture -

She said this was the wrong venue for her slot, but there'd been nowhere else to put it.

She said the Arts strengthen a person's human qualities and sense of self. Therefore they belong in mental health services and can be part of mental health healing.

She saw the Arts as Social Capital – they create an environment which adds value to the experience both of the mental health helper and the helped

“The Arts strengthen a person's human qualities and sense of self. Therefore they belong in mental health services and can be part of mental health healing.”

“The Arts create an environment which adds value to the experience both of the mental health helper and the helped.”

With respect to the afternoon's main topic - ie the law - Pirkko suggested that in one respect people in police cells, in prison and in the Immigration systems have more rights than people in mental hospital - in these three systems the individual has a legal right to one hour's exercise per day. This right does not extend to mental health hospitals.

One other point made in this session was that there are more people with mental health problems in American gaols than in American hospitals.

Day Four : Sunday

Am. Plenaries : Old Age and mental Health

Speaker : E Chiu, Australia. The Partnership between Old Age Psychiatry and Physicians

The speaker spoke of a tendency in psychiatry to neglect the range of problems faced by old people.

For instance it has been found that people who have a sense of spirituality - something transcendental - in old age do better from a mental health point of view than those who don't.

All health disciplines are relevant to the problems associated with old age and have to work closely together.

Speaker : J Kulkarni : Women and Schizophrenia

The speaker gave a rather technical and medically-orientated talk - graphs etc

She said that physical treatment methods that come from Kreppellin's days are challenged today. Oestrogen can lead to Depression, which in turn can accelerate Schizophrenia

Speaker : D Stewart, Canada : An International Approach to Improving Women's Mental Health

Self help group in Guatamala had improved mental health through production of beautiful fabrics for sale - provided income and gave a sense of self-worth. Mental health improved.

Human rights and the combating of sexism all has to do with women's mental health and this remains especially pertinent in the developing countries, in which tradition is still a potent force in the middle of rapid change.

Pm : Workshops

Speakers : K Salonen, "The Citizen as Municipal MH Policy maker"
T. Heiskanen, "How to Build up a municipal mental health programme to support citizen's well-being."

The speakers (colleagues from the same town in Finland) presented in turn different aspects of an exciting venture that not only invited a whole locality to involve itself in mental health issues, but involved the local press in helping them do so. In itself the exercise drew a community together and both promoted its good mental health and challenged its own prejudices all at the same time.

The task began by educating the media, involving them in big focus groups composed of local people from all walks of life, which then became a story in the local press.

The local press were sceptical at first, but then enthusiastic.

See Appendix Two of this report for more detailed paperwork on the Finnish initiative.

Speaker : D Ridley “Trust us - We’ve come to help you”

The speaker was an English free-lance psychologist, used as expert consultant to help Russian services start up in a town near the Urals.

Various issues that had to be addressed - ie his own fee as an outside expert cf. the local workers’ fees, which are tiny. Unlike some consultants, he worked to the principle of as much parity as possible.

Similarly, he worked to make himself redundant, so that local services could do without him once his spell was over.

The speaker observed that market forces rule in Russia, more at present than perhaps anywhere else, which - in his experience - could lead to medical mis-diagnosis in some cases.

Speaker : S. Niemiec (an Australian reporting on a project in Newcastle, UK).
“Implementing A Psychiatric Crisis Resolution Team and Home Treatment Service in the UK”

The speaker described a badly functioning all-purpose team, unable to cover its workload. Delays and confused priorities.

The overall service was greatly improved under various headings and measures, by creating a separate crisis resolution team.

Speakers : F Puente etc “A National System for Psychological Counselling by phone - Mexico

The speakers were psycho-analysts. They had created a service which provides volunteer and professionals counsellors on the phone.

It has been running for ten years, and remains open 24 hours a day.

The speakers proposed it as a model which combines low budget, voluntary commitment, and education, with an effective answer to urban needs.

It offers information about local services, support and counselling, crisis intervention, and telepsychotherapy.

It is recognised as a successful service and has spread to other locations. It enjoys high profile political support.

Speakers : Rogan Wolf and Robin Hanau - “Common Courtesies - A Code of Professional Conduct for Ward Rounds and Similar Meetings”

Robin described the code in general terms and - to explain the need for the code - read out two written testimonies from members of the Westminster user groups.

Why are wards rounds “User Unfriendly ?”

The medical model assumes Age of Reason detachment and objectivity (tho’ here misplaced).

Other professions, non-medical but apparently lower in the hierarchy, have submitted to traditional ward rounds over the years.

A tendency across all healthcare services to retreat into emotional detachment as a protection from pain. Detachment is not unique to the medical model.

ie the “management model” is often equally careless in its treatment of people, eg. some of the approaches to user consultation now current.

So how can care services best support their staff not to retreat into detachment ?

Does the ward round code apply outside a mental health specialisation ?

Does it apply beyond the UK ?

Rogan described the process by which the code was produced - the original idea, the slow work of reminiscence within the groups, the politics of the negotiations with the local services and finally the decision to make it policy.

Robin mentioned the OpenMind article, the APPG presentation a few months earlier, and our hopes that eventually it will become a national standard in the UK.

The speakers displayed the code and read from selected parts of it. Rogan then discussed some of the issues and problems they’d encountered in the actual implementation of the code and some recent ideas in winning greater acceptance for it.

The presentation ended with some suggestions for why the code might be necessary – what did it mean - that meetings conducted over years by caring people should have been allowed to become so insensitive and disrespectful ?

○ It had something to do with the medical model’s detachment and objectivity (here misplaced).

- Something to do with system hierarchies, since members of other professions, non-medical and apparently lower in the hierarchy, have submitted to ward rounds over the years, despite unease.
- But he also suggested that detachment is not unique to the medical model and that the “management model” is often equally careless in its treatment of people, ie some of the approaches to user consultation now current come close to abusiveness.
- This detachment might have something common with all healthcare services - a tendency to detach as a defence against too much pain and disorder. Which

leads to the question, how can care services act to off-set the tendency among their staff (as with all human beings) to detach from pain and disorder ?

The speakers concluded by also wondering whether the code applied beyond mental health and whether it applied beyond the UK.

Audience enthusiasm (admittedly sparse in number) suggested that it did. The speakers from Finland and Mexico asked for their own copy. An advocacy Worker from Northern Australia, a politician from Victoria and a psychiatrist from Western Australia also took the code away with them. Later, the Director of a mental health counselling service in New York asked for a copy.

On the last day of the conference, Rogan presented the code to the WFMH Board and asked them whether they could give it their support. A few weeks later an e-mail response came from Pirkko Lahti, now acting as ex-President : “Thank you for the material. The Board of the World Federation discussed it and was very satisfied enthusiastic about it. It will be forwarded to our Consumer and Carer Advisory Group for further preparation.” It has since moved on to another working group, of which Pirkko Lahti is a member. See Appendix Three of this report for a copy of the code and of a hand-out used for the presentation .

“Thank you for the material.

The Board of the World Federation discussed it and was very satisfied with and enthusiastic about it. It will be forwarded to our Consumer and Carer Advisory Group for further preparation.”

Pirkko Lahti

Day Five Monday

Am – Plenaries

Speaker : Sharon Burrow, Union Leader - “Respect for Workers”

This was a powerful talk from a powerful woman. It was notable that she was given a great deal of respect and status by colleagues on the platform, suggesting that union leaders in Australia have more standing than their counterparts in this country – at least at present. And she behaved, not as underdog nor rebel, but simply as leader with weight on her shoulders, facts at her finger tips and lots of meetings to hurry on to.

Her talk was a vivid description of stress at every level, threatening mental health. There was an irony in this for members of the audience involved with organisations that provide services for the unwell. For while Ms Burrow was talking with such clarity of a disfunction across Society that makes far too many people reliant on mental health services, she might just as well have been describing those services themselves. The pressures and anxieties that do such harm in Society at large are at work among the helpers too.

Stress in the Workforce

Mental Health is one of the primary issues of the 21st century.

1 in 4 workers take time off for stress.

An Australian Study interviewed 10,000 people and found that accidents at work are closely linked to the stress experienced by workers – stress leads to the accidents.

Workers' definition of stress and what caused it :

40% found that stress is caused by top-down pressures -

- **lack of consultation**
- **a macho workplace culture in which management is conducted without inter-personal skills, just passing down threat and anxiety**
- **increased workload/ inadequate staffing/excessive performance monitoring**
- **activity based on fear rather than on confidence**
- **long working hours/fatigue among workers**
- **lack of family friendly work-places**

Workload across the world has increased and this adds to stress -

people feel constantly snowed under : physical symptoms – tiredness, depression, memory loss, high blood pressure/ulcers/ indigestion

Nowadays all workers have to face job insecurity – and massive continuous change.

A national code of practice is needed to establish a standard on how to reduce stress levels.

She said that mental health is one of the primary issues of the 21st century.

She said, if we are truly interested in giving respect to the work force, we have to be interested too in effective strategies for relieving stress. 1 in 4 workers take time off for stress.

She reported on a major study that had recently been carried out by her Union. 10,000 people were interviewed.

Accidents were found to be closely linked to the stress experienced by workers – stress leads to the accidents.

Workers were asked for their definition of stress and what caused it :

40% of the answers found that stress was caused by pressure from above

ie lack of consultation

a workplace culture which allowed intimidation, an atmosphere of threat

increased workload

inadequate staffing

excessive performance monitoring

activity based on fear rather than on confidence

long working hours/fatigue among workers.

lack of family friendly work-places

The conclusion is that workload across the world has increased and this adds to stress -

people feel constantly snowed under

physical symptoms – tiredness/depression/memory loss/high blood pressure/ulcers/indigestion

She said that the union had organised a phone-in campaign on bullying. There had been a massive response. Managers were bullying as a way of managing. They needed training to teach them to lead through the use of inter-personal skills.

Nowadays all workers have to face job insecurity – and massive continuous change.

She suggested a national code of practice is needed to establish a standard on how to reduce stress levels via test case benchmarks.

Speaker : Yam Amoto – “A Socially Healthy Global Community”

The speaker talked of global anxiety as a result of the recent Bali bomb. Mental health everywhere is affected by events and developments anywhere.

Speaker : S. Peltovuori : From Values To Choices

The speaker talked of the significance of the family in the European framework. She discussed the question of stigma ; and how the recovery or creation of mental well-being depends to a major degree on overcoming stigma. Stigma also puts stress on family members, she said.

Speaker : E Matare : Multi-Cultural and Indigenous Mental Health

The speaker came from Zimbabwe and began by making no apology for the absence of lap-top technology in her talk. She said that Africa had very few power points ; computers in Africa were fewer still. In Melbourne, as in Africa, she would be relying on the spoken word.

She emphasised the need for a multi-cultural approach to mental health. She meant by this that cultures need to meet each other and respect each others' differences.

She compared it with the “melting-pot” model, in which differences are assimilated into a single whole, where all particularities are expected gradually to disappear. On the face of it and in theory, differences are tolerated in this model, but not acknowledged as a strength. And really the view here is that multi-culturalism divides people and costs too much ; it is only for the minorities, not the mainstream.

But the speaker saw multi- culturalism as an enriching thing, which allows, respects and maximises differences. She said that “pride in one’s own cultural heritage promotes good mental health”.

The speaker talked of the refugee problem in Africa, caused by the continent's wars. The effects on the indigenous peoples were profound, she said. Non Africans assume that Africans share the same culture but this is wrong, of course – there are huge differences. One obvious example is that some peoples eat Yam as a staple, others Maize. And in Africa there is often no choice in what you eat. You take whatever is locally available. This adds to the trauma of being a refugee in a strange country - to be deprived of your staple diet along with so much else that you were used to.

She said there were no support systems for refugees, no resources. And if there were mental illness in the family, the stigma is such that you might not dare to disclose it. Consequently you might feel pressured to hide your ill family member away.

The speaker talked of the need for education, health promotion and publicity. She suggested that the media should be invited to conferences of this kind, as a way of educating them, so that they too could then take some responsibility for and play a role in, educating people in countries where mental ill health is still little understood.

She mentioned the HIV/AIDs epidemic and the need for support for the psychological effects this has on a whole population. She said that mental good health knows no boundaries. Mental ill-health knows no boundaries either.

She was a passionate and eloquent speaker and aroused passion from the audience. An African-American psychiatrist, quite elderly, spoke with beauty and pain of his own "deep soul injury" in "not knowing who you are – what you should be". He recommended that African Americans should spend time in Africa to re-establish their roots – as he had done. But do not expect the visit to be comfortable, he said. The place of your roots may not leave you feeling any more at home than you feel in your adopted country.

A Multi-Cultural Approach to Mental Health

Multi-culturalism as an enriching thing, which allows, respects and maximises differences.

“Pride in one’s own cultural heritage promotes good mental health”

Within Africa there is extra trauma for refugees –

- **Different staple diets**
- **No support systems, no resources.**
- **Families might hide mentally ill members away because of the stigma.**

The media could play a role in educating people in countries where mental ill health is still little understood.

Mental disturbance and distress know no boundaries.

“Not knowing who you are – or what you should be” causes a “deep soul injury.”

But the place of your roots may not leave you feeling any more at home than you feel in your adopted country.

Pm : Workshops

Speaker : Shula Ramon The Value of User Research.

Shula Ramon is an academic from the UK, a long-standing advocate for the user movement and user issues.

She presented her work co-ordinating a number of research projects in which the bulk of the research was carried out by people who are current users of mental health services, in partnership with professional researchers.

This work therefore seemed very similar to the User Focussed Monitoring programme practiced in Westminster and Kensington, piloted originally by the Sainsbury Centre.

Dr Ramon spoke of the advantages to be gained from having the “unmediated view of users of a service,” as well as this being an opportunity “to enhance our social capital and community building by investing in creating a group of user researchers.”

She described the training offered – three months in which the logic and ethics of research were presented and the skills of listening, interviewing and recording fostered.

Day Six - Tuesday

Am - Plenaries

Speaker : Jean Cambell : Partnership between Consumers and Professional Providers

Jean Cambell spoke as a service user and advocate. She saw partnership between service providers and service users as the way forward, rather than the old treatment models. The consumer view-point and experience was too precious to be left out, but still and too often users/consumers are defined by their “differentness” rather than as full persons. “Each person has a name,” she said. “Each person has a story”.

Thus the “therapeutic alliance” and the need for a greater concern with the “*quality* of service delivery” than for the outward form of it.

A service of high quality offers close personal Contact, good Communication and genuine Concern. It also ensures that full information is supplied, since information withheld creates a division between service and service user, it dis-empowers and encourages passivity, a giving up.

She mentioned a string of studies since the 60’s, all of which have found that physicians who offer an affiliative approach get greater job satisfaction ; while patients who experience warmth from their physician show a higher rate of improvement.

Partnership in Mental Health Working

Users/consumers are still often defined by their “differentness” rather than as full persons. “Each person has a name, each person a story”.

The “therapeutic alliance.” The “quality of service delivery” is more important than any official line or measurable count.

A service of high quality offers :

- **close personal Contact,**
- **good Communication**
- **genuine Concern.**

Also full information – since information withheld creates division, disempowers and encourages passivity.

Studies keep finding that :

- **physicians who offer an affiliative approach get greater job satisfaction**
- **patients who experience warmth from their physician show a higher rate of improvement.**

She referred to the User Focused Monitoring approach to research and to the club-house model as examples of a partnership approach to health “recovery” and “improvement.” People who are offered these services are seen and treated as “guests,” or as “members” (of a community). In these conditions, one begins to re-build a sense of self, one learns to speak for one self.

Speaker : Mary O’Hagan : Force in Mental Health Services : International User/Survivor Perspectives

The speaker gave some history of the use of force in 18th Century treatments.

She condemned all use of force and compulsion in mental health and issued a strong critique of the bio-medical model.

There was an interchange between the speaker and a psychiatrist who emphasised that in some mental health situations, taking away someone’s liberty and forcing treatment on him or her is the only loving/caring and socially responsible thing to do.

The speaker was clearly used to this argument and gave a kind of parable in reply. She said that a physically handicapped person went swimming on a beautiful day. As a result of her handicap she was an untidy swimmer and to an outsider it looked as if she were in trouble. A life-guard swam out to save her : “Don’t you worry, I’m here now. I’ve come to save you from drowning.”

“And don’t *you* worry,” she said. “And kindly leave me be. I’m not drowning. I’m swimming - in my own way.”

Although the answer won some applause, one felt that the speaker had not necessarily won the argument. The use of the word “love” by the psychiatrist was powerful (and unusual) and hung in the air after the other words had stopped. Somehow the interchange had not advanced the argument very much. It is a difficult argument. Others will continue it.

Mary Hemingway Reece Lecture

Tim Costello : Religion – does it heal or hinder mental health ?

When Robin reported back on the *last* WFMH Congress, in Vancouver, he described a rather special talk on Spirituality and Mental Health which he had attended. This was by Julie Leibrich, from New Zealand. If anyone is interested to look up this paper, it can be found on the web-site of the charity Hyphen-21, whose address is included in Appendix Five. The paper is there by permission of the author.

The Mary Hemingway Reece Lecture takes place at each Congress and is always concerned with issues of spirituality. This year the speaker was Tim Costello, a local reverend based in St. Kilda, a town on the coast, near Melbourne. He is well-known in Australia for his work with the homeless.

He spoke of a spirituality gap – and tried to put some words to “spirituality.”

He suggested these ideas :

- the call that resonates in each of us at some point, “who am I ?”
- a sense of transcendence ;
- the things and values and experiences that matter most ;
- the sacrificial commitment - that which you might be prepared to stand for, whatever the personal risk ;
- being whole/becoming well, becoming healed ;

Can Religion help in Issues of Mental Health ?

The self can only know itself in relation to some other. The Latin word *religio* = to bind together/bind back to the sacred.

The spirituality gap - a yearning for a sense of the sacred

“Religion is for people who are frightened of going to hell ; spirituality is for people who’ve been there.”

“Sick religion” offers :

a sense of belonging that is exclusive and condemning of “outsiders” ; false promises of health, wealth and salvation.

A healthy religious centre is good at making a community happen. This community will tend

to be counter-culture to haste, distrust and insecurity.

support a way of human life that can be celebrated

empower and liberate people.

The religious calendar is not performance driven, but offers sacred space. Outside – “if you can’t measure it, it isn’t real”. Inside - rituals that support non-measurable time.

In the healthy religious community people share with each other their stories of pain, stories of hope.

- the thing that makes you ask of yourself, “do I matter to anyone ?”

He proposed that the self can only know itself in relation to some other. He gave us the meaning of the Latin word *religio* - to bind together/bind back to the sacred.

The spirituality gap is therefore a yearning for a sense of the sacred, and is caused for many people by an inability at the present time to find a sense of the sacred in the various established churches and faiths.

He suggested (not altogether seriously) that religion is for people who are frightened of going to hell ; spirituality is for people who've been there.

He suggested too that there is such a thing as sick religion – which offers a sense of belonging that is exclusive and condemning of “outsiders,” false promises of “health and wealth”, a false and facile hope of salvation, etc.

He himself liked being of the church, he said. He thought a church is rather good at making a community happen - it does it well. The community is religion-based, of course, and – if its religion is not sick - will therefore be counter-culture to haste and to distrust and to insecurity. It will have a tendency to support a form and way of human life that can be celebrated ; it will have a tendency to empower and liberate people.

His church had various other features, all counter-culture. For instance, the community there followed a calendar that was not performance driven, but on the contrary offered sacred space. Outside, more and more – “if you can't measure it, it isn't real”. Inside, are rituals that support non-measurable time.

In his community, people shared with each other their stories of pain, their stories of hope.

Pm Workshops

Robin attended a workshop on Buddhism and Mental Health. A paper by the speaker is enclosed in Appendix Four.

Day Seven : Wednesday (last day)

Am : Plenaries

Speaker : F Goodwin : The Prevention of Suicide : Are we finally making progress ?

The speaker, from the US., said that the prevention of suicide presents two challenges – one, identifying those at risk ; and two, selecting the most appropriate treatment.

He said it was critical to recognise that the great majority of suicides occur as a

consequence of untreated or inadequately treated psychiatric illness, principally severe depressions and bi-polar disorder.

He said that, among people with a major depressive disorder, prior attempts or suicidal “ideation” were not necessarily a sign of real suicide risk. On the contrary, “among the highest risk group [major affective disorder], those who suicide actually expressed less severe ideation than the comparison group who did not suicide”

The speaker went on to describe findings of the effects of various medications on various groups of people suffering from various forms of unhappiness.

The presentation was highly detached and medically-orientated, and a surprising choice for the final day of a major conference. It left several in the audience – a few of whom would have identified with the some of those experiences labelled “major

affective disorder,” “severe ideation” etc – not only distressed but offended.

Suicide and Mental Health

Suicide is the 8th most common cause of death

Among young people 15-34 years old it is the 3rd most common.

50% of all successful suicides constitute the first attempt.

Studies in the 70’s found that “hot lines” made no difference [?! - ed]

Major Depression is the mental health diagnosis most closely linked to suicide

Previous “ideation” has little connection with successful suicides. Prior suicide attempts also not much of an indicator that someone will eventually succeed.

Positive indicators :

a history of violent impulsive behaviour. (Most successful suicide attempts are violent. Attempts that fail tend to be non-violent).

Histories of depression and of “global insomnia” ; these combine with “hopelessness” and substance misuse to form a cluster of indicators of high risk.

Lithium still “all we have that can save lives” (?)

Speaker : John Connelly :
Suicide prevention

Dr Connolly, from Ireland, gave us a run-down on suicide findings.

He said that suicide is the 8th most common cause of death. Among young people 15-34 years old, it is the 3rd most common.

He said that 50% of all successful suicides constitute the first attempt.

Studies in the 70’s found that “hot lines” made no difference.

The mental health diagnosis most closely related to suicide is Major Depression.

He said that studies found that previous “ideation” has little connection with successful suicides. Prior suicide attempts are also not much of an indicator that someone will eventually succeed.

What *is* an indicator, he said, is a history of violent impulsive behaviour. Most successful suicide attempts are violent. Attempts that fail tend to be non-violent.

Histories of depression and of “global insomnia” are both indicators and combine with “hopelessness” and substance misuse to form a cluster of indicators of high risk.

Dr Connelly appeared to differ from the previous speaker in concluding that – for the medical practitioner seeking to treat people at serious risk from suicide, Lithium is still “all we have that can save lives.”

Following this second talk, the first speaker Dr Goodwin walked across to Dr Connolly where he sat on the stage, and stood over him and with Dr Connolly’s microphone in his hand, proceeded to bombard him with a rapid succession of highly technical and also aggressive questions which Mr Connolly *appeared* to answer satisfactorily. Dr Goodwin was very tall, thin and austere, with grey hair, cropped military style. Dr Connolly was short and rotund, suggesting a rather more genial life-style. The two made a striking contrast within inches of each other on the stage, talking the technology of suicide research, gladiators locked in verbal combat in front of an audience of several hundred.

Afterwards Mr Connolly said he would be staying on in Australia for a few days - for the fishing. In the afternoon feed-back session, Rogan suggested that the topic of suicide had been a powerful one for some in the audience who were less good than the speakers at studying the subject from a place of detachment. He suggested the topic should not have been left until last in this conference. The point was accepted.

Final Afternoon

The afternoon was given over to an interchange between the WFMH Board sitting on the platform, and the conference delegates in the auditorium. The delegates were invited to make recommendations to the Board “for global advances in Mental Health.” It was at this point that the delegates from London W2 put forward the Code of Professional Conduct for Ward Rounds and Other Meetings, the support of the outgoing chair having already been obtained. The code was accepted for perusal.

Those readers of this report interested in some of web-sites mentioned, or particular papers referred to, please consult the appendices that follow.

3. Appendices

Appendix One

Excerpts from Australia's national mental health strategy, giving some details on their approach to mental health promotion in the media and in schools.

Appendix Two

“Cornerstones for mental Health”

A Finnish Strategy for Mental Health Promotion

Appendix Three

a/ A copy of Westminster's “Code of Professional Conduct for Ward Rounds and Other Meetings”

b/ The hand-out given out at presentations of the code

Appendix Four

A paper : “Buddhism and psychiatry : confluence and conflict” by Graham Meadows

Appendix Five

Contact Details

Appendix One

AUSEINET - THE AUSTRALIAN NETWORK FOR PROMOTION, PREVENTION AND EARLY INTERVENTION FOR MENTAL HEALTH

Auseinet seeks to facilitate the implementation of mental health promotion, prevention and early intervention and suicide prevention initiatives in the mental health and other sectors. This involves actively working with State and Territory governments as well as consumer and carer and Aboriginal and Torres Strait Islander groups. Auseinet's website address is: <http://auseinet.flinders.edu.au>

- Auseinetter has been distributed to approximately 8000 on the mailing list.
- Average monthly hits to the website of 94,637 which is an increase of about 59% since June 2002.
- The e-journal has a subscriber list of over 400 (nationally and internationally).
- The Auseinet network of key stakeholders and sectors consists of more than 5337 individuals and organisations.
- The online searchable Resources Database including PPEI and suicide prevention programs, research and resource materials contains more than 800 records from 268 sources, and more than half of these were published within the last two years.
- A network of consumer and carer organisations with approximately 300 on their database.
- The National consultation on the Action Plan 2000 held 35 consultation forums throughout Australia with 1751 participants representing a wide range of sectors including health, education, correctional services, non government organisations, consumers, carers and university departments.

MINDFRAME (NATIONAL MEDIA STRATEGY)

The Mindframe National Media Strategy seeks to influence the media industry to report mental illness and suicide issues responsibly. It has been developed in collaboration with key stakeholders including the media industry, mental health promotion and suicide prevention experts and consumer and carer groups. Initiatives include: media monitoring research, resources for media professionals, media awards, resources for community action against stigma, and curriculum resources for journalism and media studies students and educators.

- Mindframe media resource was launched on 22 August 2002 at Parliament House with 70 attendees.
- The resource has been mailed out to around 1500 media professional.
- 13,272 hits to the web site including 160 downloads of the full pdf version of the resource since the launch.

SANE Stigma Watch Program

SANE Australia's web-based StigmaWatch program has been established to promote accurate, respectful and sensitive reporting of mental illness and suicide in the media in all its forms — print broadcast, film, advertising, internet. Members of the public can alert StigmaWatch to examples of reports in all forms of media that they consider inaccurate or include discriminatory references to mental illness. Under this program SANE contacts the broadcasters or publishers to encourage and inform them of how to report more accurately

and sensitively in this area. StigmaWatch collects complaints and provides a list of the reports and responses and a Good News section acknowledges positive and appropriate reporting of mental illness and suicide. The StigmaWatch program and publications is available at <http://www.sane.org>.

- To October 2002, StigmaWatch had investigated almost 200 reports covering print (43%), TV (30%), radio (9%), advertisements (9%) and internet (4%).
- 90 journalists were provided with information and 69 reports are documented on the web site, including 13 Good News items.
- There were 44 positive responses from media approached by StigmaWatch and 29 responses from media re the SONY activity, 12 from the Annual Report on the Media and more than 25 from the Sabre/Fudge campaign.
- 4,000 copies distributed of the Annual Report on the Media

MINDMATTERS: A MENTAL HEALTH PROMOTION PROGRAM FOR SECONDARY SCHOOLS

MindMatters places mental health on the agenda in secondary schools throughout Australia, employing a comprehensive, whole school approach that acknowledges the importance of the school as a setting for promoting mental health and wellbeing. MindMatters provides a range of resources, supported by professional development activities and a dedicated website: <http://www.curriculum.edu.au/mindmatters>

The implementation phase of the program was launched in March 2000 and is being managed by two national education organisations, the Australian Principals Associations Professional Development Council (APAPDC) and the Curriculum Corporation and has cross-sector support from the three school education sectors in all States and Territories.

- As at December 2002 65% (1831) of Australian secondary schools have participated in professional development. This has involved over 17,300 participants.
- During 2002 the website has had a monthly average of 930 visitors.
- A recent survey has revealed that awareness of MindMatters in the general community has risen from 17% in 2001 to 21% in 2002
- To date there have been 67 overseas sales of the kit and 1,667 total national sales, in addition to the 3582 kits which were distributed free of charge, including to all secondary schools.
- The first conference held on 8-9 November 2002 drew approximately 400 participants.

MINDMATTERS PLUS

MindMatters Plus will assist MindMatters schools, in conjunction with their local communities, to achieve better mental health outcomes for students with high support needs.

The Australian Guidance and Counselling Association (AGCA) is managing the program/strategies elements of the initiative, providing support to schools and local partnerships, and developing links with services and systems to increase the local infrastructure to support students with high support needs. The Australian Principals Associations Professional Development Council (APAPDC) is responsible for the national MindMatters infrastructure, management of the demonstration schools, development of training materials, and the professional development and ongoing support of staff.

- 62 schools from all States and Territories and education systems submitted an expression of interest to participate in the MindMatters initiative from which 17 schools were selected.
- 11,537 students will participate.

Appendix Two

Mielenterveyden Kulmakivet

**Promotion of mental health
is everybody's task –**

**Everybody's mental health
should be promoted**

Cornerstones for Mental Health (in Finnish: Mielenterveydenkulmakivet)

Introduction

The Project aimed to investigate the overall national situation in the field of mental health. Furthermore, the Project aimed to promote and support mental health in Finland by - increasing awareness of mental health issues in societal discussion and decision-making - increasing people's knowledge about mental health issues (own responsibility and duty) - emphasizing the citizens' points of view and taking their views and experiences into account in societal discussion and decision-making - actively promoting mental health issues in Finnish society (cross-administration, transparency of the project)

Background

The three-year project, Cornerstones for Mental Health, aimed to support mental health and promote the earliest possible prevention of mental health problems. The project emphasized taking into account citizens' points of view and their experiences in mental health. The project operated on a national, municipal and local level in order to reach maximum national coverage. The project co-operated with the Ministry of Social Affairs and Health, the provinces, The National Research and Development Centre for Welfare and Health (STAKES), the municipalities and several NGOs. The project is financed by the Finnish Slot Machine Association.

Pilot municipalities are creating mental health policy programmes

Three pilot municipalities: Hämeenlinna, Inari and Ylistaro, participated in this project aimed to create a mental health policy programme for themselves. These programmes are based on a larger view of mental health, cross-administration and citizens' points of view, and they are based on each pilot municipality's own cornerstones for mental health.

Interaction and implementation of the project at the municipal level will guide the project's activities in the same direction and create a joint frame of reference.

Voluntary workers for FAMH - Grass roots activists

Seven voluntary local mental health associations (Jyvaskyla, Kangasniemi, Lohja, Mikkeli/ Ristiina, Oulu, Pyhaselka and Vakka-Suorni) worked in close cooperation with local operators to develop various activities to support citizens' mental health. Each association had chosen its own target group and set its goals accordingly.

A consensus meeting to coordinate mental health policies in municipalities

A national, broad-based and inter-disciplinary consensus meeting was held in Helsinki from September 30th to October 2nd 2002. The participants sought to formulate a consensus statement on mental health and also outlined a joint mental health policy programme for public distribution and for use by various organisations. Some follow-up procedures for this initiative were also specified.

Civic journalism - will it stimulate public discussion?

Civic journalism - experiment took steps to make citizens active participants who will influence mental health issues in their municipality and encourage public discussion of important issues. This experiment was carried out in October 2001 - August 2002 and was financed by a separate grant from the Finnish Centre for Health Promotion (FCHP).

Internet helps promote the mental well-being of the public

The mental health know-how centre , which is currently under construction, aims to serve both the public and experts. The know-how and information sections will strengthen people's ability to cope.

Evaluation is supporting the whole project

Each part of the project's agenda is subject to both internal and external evaluation. Internal evaluation is based on project diaries and self-evaluation forms. The external evaluation has been performed by the Finnish Centre for Health Promotion (FCHP).

Recommendations by the consensus panel

These recommendations are based on expert group discussions and addresses held at the Mental Health Consensus Meeting (from September 30th to October 2nd 2000 in Helsinki, Finland):

Cornerstone # 1 Securing the Safe Growth and Development of Children and Young People

1. A sufficient standard of living for families with children should be secured.
2. The skills and resources of parenting should be supported.
3. Family life and the demands of the work place should be harmonized in a manner supporting the family.

Cornerstone # 2 Strengthening of Community Spirit and Involvement

1. New opportunities for participation should be guaranteed and, if necessary, created, and the know-how required for participation should also be ensured.
2. Citizens' opportunities to become heard and to influence common issues should be improved.
3. People's mutual support and feeling of togetherness should be enhanced.

Cornerstone # 3 Good physical, mental and social environment

1. People should be given the practical means to influence the planning of their environment and the decision-making regarding it.
2. People's environments should be built with care and maintained properly. Social inequality should be fought against.
3. Information about living conditions and environments should be collected systematically to facilitate municipal decision-making.

Cornerstone # 4 Sufficient basic security

1. People should be supported and encouraged to earn their living by their own work.
2. Problems of everyday life should be prevented by supporting people and dealing with their problems at the earliest possible stage.
3. People should be guaranteed housing suitable to their respective life situations.

Cornerstone # 5 Good mental health services

1. Mental health promotion should be everybody's concern and people should define their duties and action accordingly.
2. Problem situations should be identified early and dealt with actively.
3. Quick help is essential in a crisis situation.
4. The quality of life, standard of care, nursing and rehabilitation of long-term patients should be assured.

What about the future ?

National mental health programmes have been established in only a few countries, but Finland is not yet among them. Finnish legislation requires that municipalities provide their citizens with mental health services and living conditions that support citizens' mental health.

What makes the Mental Health Cornerstones Project so unique is the re-thinking of the role of an NGO. The NGO (Finnish Association for Mental Health) is seen as an organisation that keeps the citizens' point of view in mind and, in collaboration with municipalities, actively helps prepare municipal mental health programmes. It also gives recommendations concerning subjects and factors that should be considered in making decisions regarding the support of mental health.

The FAMH wishes to continue collaborating with the three municipalities already participating in the Project, to spread knowledge about mental health to other Finnish municipalities and thus facilitate the preparation of their mental health programmes.

The FAMH has successfully applied for an extension of the Project's funding. You will find more information about our Project's future plans in June 2003 on the Internet: www.mielenterveysseura.fi/talkoot.

Appendix Three



A CODE OF GOOD PRACTICE FOR MEETINGS WITH SERVICE USERS (eg Ward Rounds and CPA Meetings)

This Code is for the benefit both of mental health service users and their multi-disciplinary support teams. It sets out the conditions necessary for an atmosphere of care and respect to flourish.

The Code applies to all multi-disciplinary meetings, ie ward rounds, Section 117 meetings, CPA meetings. Since CPA meetings usually take place in the community and the term “service user” is now widely accepted for people with mental health problems living in the community, the code will use that term throughout. For people in hospital the term “patient” would of course apply.

PREPARATION FOR THE MEETING

Thought should be given at all times to the service user’s comfort and dignity.

The Primary Nurse/Key worker should explain beforehand what the meeting is for. The service user’s right to confidentiality should also be explained.

It should be made clear that a service user’s attendance at a CPA meeting or ward round is voluntary.

Service users may choose instead to meet one of the professionals involved in the team, either beforehand or afterwards.

Service users should also have the opportunity to see that professional in a different setting if they so choose.

On the other hand, if a service user is not admitted to to his/her ward round or CPA meeting, the reasons for this should be given.

PEOPLE PRESENT

Professionals : the number of professionals present should be kept to a strict minimum - say, three or four. All workers present at the meeting should be introduced to the service user and their reason for being there should be explained. The reason should always be for the service user’s benefit.

Advocates/Family Members : Should a service user wish to bring a family member, friend or an advocate to the meeting, this must be facilitated and encouraged. The service user should inform the meeting beforehand.

Students : students should attend the ward round only with the service user’s permission.

APPOINTMENT TIMES

Each service user should be given an appointment time, as well as relatives or other key individuals who are expected. The times given should be adhered to as closely as possible. When this is difficult, good practice would be for service users to be seen within fifteen minutes of their stated appointment.

There should be a named person responsible for facilitating the smooth running of appointments. In the case of Ward Rounds, this person’s name should be recorded above the list of appointment times.

If there are delays longer than fifteen minutes, an apology should be given as early as possible to those still waiting and they should be told how long they might expect the delay to be.

PUNCTUALITY

Meetings should start on time and all professionals involved should aim to be present from the start. Latecomers should only be admitted if they are expected and they should be introduced to the service user. They should apologise for their lateness and explain it. Professionals who have to leave early should explain the reason for their departure and time it in such a way as to cause the least possible disruption.

SEATING

Seating should be arranged so that the service user is part of the circle, not at the centre of it. The ward round should be conducted in a way that ensures the service user feels as much part of a discussion as possible, rather than at the centre of a cross-examination.

REFRESHMENTS

Where refreshments have been provided for staff, service users should be offered refreshments too.

QUESTIONS

Questions should be asked in a respectful manner. Thought should be given as to who is the most appropriate person(s) to ask those questions in each case - it should not automatically be the psychiatrist.

Service users should also speak to their multi-disciplinary team in a respectful manner.

The service user's mental or emotional state should not be insensitively examined in public and amongst strangers with tests which lower his/her dignity.

Questions to which workers already know the answer should not be asked.

Unless it is judged to be absolutely necessary, service users should not be asked questions which take them into painful or intimate areas of their lives.

MONITORING/EVALUATION

The Code can be monitored by Advocacy Workers and through Audits. Equally, it can be monitored regularly by the teams themselves, who can support each other in ensuring it is followed.

This code was developed in close consultation with the North Westminster Forum (NWF) and South Westminster User Involvement Group (SWUIG). An earlier version was published in Openmind in 1998. The code is currently displayed on the website of the Sainsbury Centre for Mental Health. It is now policy across CNWL Mental Health NHS Trust, and various other Trusts have since adopted similar codes. In November 02 it was presented to the All-Party Parliamentary Group for mental health in Portcullis House, Westminster. The code was conceived, and the process of implementing it facilitated, by Rogan Wolf, Secretary of Hyphen-21, a registered charity that seeks to support the connections that make community, chiefly through promoting good practice in health and social care. Its web-site is www.charts.force9.co.uk



PROPOSALS FOR IMPLEMENTING THE MEETINGS CODE

- that the code recognised and agreed as being the best available should be instituted methodically and as widely as possible, rather than a range of different versions be applied piecemeal.
- that it should be instituted in such a way as to ensure that all staff and all patients are kept aware of it (bearing in mind staff and patient turn-over).
- that its effective practice should be encouraged and underpinned not just by Audits and Directives, but by a Trust requirement that all psychiatric and Community mental health teams should review their practice in ward rounds, CPA and other meetings on a regular basis, with a view to taking shared and multi-disciplinary responsibility for ensuring the Code is upheld.
- There should also be training input, with the Code made part of Induction packages, to enable new staff to be introduced to the code as something more live than just words on paper, and to enable some psychiatrists who favour the code to present its benefits to colleagues who are sceptical (this last idea was suggested by a psychiatrist).
- that Healthcare Trusts should state a position on the “Own Space” model advocated in Strathee’s paper, which advocates the effective dismemberment of the traditional ward round, and should require each of their psychiatric and sector teams to begin to move towards this or a similar model, reviewing its progress on a regular basis, always ensuring that that progress remains in accord with the precepts outlined in the Meetings Code attached.

Rogan Wolf



A Code of Professional Conduct for Ward Rounds and Similar Meetings

Ward rounds and similar review meetings can be deeply intimidating - even traumatic - for the mental health patients/clients who attend them.

Issues intimate and personally momentous become public property, in a circle of strangers who can remain so detached that even their names may be withheld from you. At a time when you're perhaps at your most raw and vulnerable, you are treated too often as a mere object of scrutiny, swimming about in a bowl.

A code of professional conduct for ward rounds and similar meetings can set a benchmark for ordinary good manners in these settings, to ensure that the person at the receiving end is treated as respectfully and as sensitively as possible.

The Code seeks to ensure, for instance, that the numbers of professionals in the meeting are kept to the minimum required ; that everyone present introduces themselves ; that a serious attempt is made to run a meaningful appointments system.

The Westminster user groups were the first in the country to propose such a Code. They spent nearly a year drafting it, putting together memories of what had happened to individuals, and then turning those memories into a proposal for what *should* happen, instead. The draft was published in the national magazine *Openmind* in 1998.

Since then, various Trusts have implemented this or a similar code. In 2001, the Westminster groups' local Mental Health Trust - CNWL - made it Trust-wide policy.

How to turn policy by prescription into practice of second nature, remains an issue still not fully resolved. And why such a code should ever have become necessary in the first place, is a question that's difficult - but important - to answer. For ultimately, this is a wider issue than clinical practice. As a code has proved necessary to ensure proper care is taken in *clinical* meetings, it is also becoming clear that similar codes are needed now for *managerial* staff - to ensure their *consultation* meetings with service users are conducted with appropriate skill and care.

In conclusion, the Westminster user groups suggest that, if the code of professional conduct for ward rounds and similar meetings is a policy that can be implemented by a handful of mental health Trusts, should it not be implemented by them all ?

Rogan Wolf

Appendix Four

RELIGION AND SPIRITUALITY

Buddhism and psychiatry : confluence and conflict by Graham Meadows

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Abstract

Objective: *To describe the relationship between Buddhism and psychiatry, from a personal perspective.*

Conclusions: *The paper introduces Buddhist thought for those unfamiliar with it, then describes some of the sites of confluence and conflict between this tradition and those of Western mental health care. It does so from the perspective of a westerner who has made some exploration of Buddhism, mainly this within one of the Tibetan traditions.*

Key words: *Buddhism, psychiatry, religion.*

INTRODUCTION: HISTORY OF BUDDHISM

The historical Buddha lived in Northern India about two and a half thousand years ago, and so was a contemporary of Pythagoras. He taught for many years, extensively sharing his personal experience with a wide range of audiences. The teachings spread widely, being locally interpreted in transmission, with, broadly speaking, two routes of development. One was north of the Himalayas, including the Tibetan group, eastward into China, finally into Japan and Vietnam; there was also a southerly rout including Sri Lanka, Thailand, Burma and Cambodia. Latterly, there has been an explosion of teachings in the west, with increased travel, availability of more and better translations, of accessible presentations by westerners [1] and, in the case of Tibetan teachings, the effect of the outflow of teachers consequential on the Tibetan Diaspora. Australia and New Zealand have a surprising number of these refugees and migrants, with many very senior teachers providing teachings in a wide range of traditions [2]. The recent Australian Census identified Buddhism as the fastest growing spiritual tradition in the country [3].

BUDDHIST THOUGHT

We are what we think
All that we are arises within our thoughts
With our thoughts we make the world
Speak or act with an impure mind
And trouble will follow you
As the wheel follows the ox that draws the cart

Tibetan Dhammapada [4]

Buddhist thought is very psychological in nature; a great deal of the content of Buddhist teachings has to do with promoting more positive states of mind. Included within these states of mind are states that are free of afflictive emotions such as anger, despair, and negative types of desire.

Codification of Buddhist teachings.

The Buddha's presentation of his teachings varied somewhat according to the audience and the context. As he taught in many settings over a large number of years, this could be a source of confusion. During the spread of Buddhism in Tibet, there were efforts made to reduce possible harm from this. Arising out of these efforts we have a number of versions of teachings called the "Graded Path" (see for instance [5]). Tibetan Buddhism also commonly makes use of a figure the Buddha composed within his lifetime, that of the "Wheel of Life" (reproduced as Figure 1, below).



Figure 1; The wheel of life

The wheel of life (see for instance www.buddhanet.net/wheel1.htm for a guided tour and www.digitaldharma.org/g15.asp for an extended explanation) depicts a wrathful figure grasping a large plate-like image. Around the edge of this are images depicting the "links of independent origination" - from one o'clock onwards:

1. At the base of all problems is ignorance of the true nature of reality, depicted by a blind man.

Then a further series of images convey concepts that build on this:

2. because of ignorance, we create karma

3. because of karma, we create consciousness

4. because of consciousness, we create "the aggregates"

5. because of the aggregates, we create the senses

6. because of the senses, we create contact

7. because of contact, we create suffering

8. because of suffering, we create craving

9. because of craving, we create grasping

10. because of grasping, we create conception

11. because of conception, we create rebirth

12. because of rebirth, we create death.

Within this circle are the six realms. These images can be taken as signifying: actual environments for rebirth; metaphors for different aspects of the human condition; or in more subtle interpretations, as different states of mind that lead to different kinds of suffering, which involve the subjective perception of different environments. Clockwise from the top we have the God realms, the Human Realm, the Hungry Ghosts, the Hell Realms, the Animal Realm and the Jealous Gods. Within this we have a depletion of the rising and falling of mental states with the alternation of positive and negative mental states, then in the centre we have the three root poisons of anger, desire and ignorance symbolized by the snake, the rooster and the pig. The whole of this space - psychic existence or samara – is embraced by Yama, the Lord of Death. Within the frame but outside Samsara is also a Buddha, illustrating that escape to enlightenment outside this constricted universe is possible.

Plainly, this presentation is greatly abridged. Concepts such as "the aggregates" require substantial exposition, and many of the terms which appear familiar are being used here in quite specific ways. What may be clear, however, from this summary is the extent to which the doctrines of Buddhism place a great deal of close emphasis on the nature of internal states. Allied with the doctrinal teachings are extensive meditative techniques which encourage the practitioner to become very much aware of internal states and the way in which mental states are created out of our habitual ways of perceiving things. "Habitual ways of perceiving things" in fact is one way of looking at the whole concept of karma within Buddhism. Our accustomed and habituated ways of construing the world will tend to influence how we experience it and how we respond to it.

CONNECTIONS BETWEEN BUDDHISM AND MENTAL HEALTH CARE

Theoretical Connections and the Nature of Consciousness

Western psychology is currently grappling mightily with the nature of consciousness [6] [7] [8].

Although it has made little impact yet into the thinking around clinical mental health care, where a number of conventional assumptions regarding cognitive-behavioural and psychodynamic psychology stand centre stage, waiting in the wings as it were are some radical reformulations of the nature of personhood and the mind. Consciousness theorists and investigators preoccupy themselves with issues such as the "binding problem" whereby disparate sensory inputs arriving at different times in the sites through which awareness might be coordinated seem to be experienced as simultaneous. They concern themselves also

with speculations on the nature of "zombies" or non-conscious humans - whether such creatures might exist and indeed if you were one whether you would know it or not.

Workers in this field have had a couple of reasons to become interested in Buddhist thinking.

First, Buddhism contains some highly developed models of mind based on the fruits of extended contemplative exploration of the nature of mental self [9]. Second, the techniques of meditation offer some promise in opening up the possibility of more intensive exploration of mental phenomena [10]. Buddhist techniques offer to consciousness study investigators the possibility of, to borrow a phrase from Guy Claxton [1, 11] "sharpening the gizmo" in relation to introspection on the origin and nature of conscious experience.

Practical Utility of Mindfulness and Other Buddhist Techniques for Therapists

Training in psychiatry in particular presents some psychological and mental challenges for the practitioner. Phenomenological mental state examination requires the development of a particular observing facility - a capacity to create a representation in one's own mind of the events in another, and then cogently describe this. This is a developed form of empathy that requires a certain kind of mental poise and pliancy [12]. This in itself represents a reason for seeking out techniques that may sharpen the introspective faculties.

Further reasons for seeking out techniques that may support mental health and stability include: dealing with the day to day stresses of work, with the impacts of transference and counter-transference on our own psychologies, as well as the stress of making often painful and risky decisions. My own encounters with Buddhism came in part from this root, starting out in psychiatry and feeling that some kind of relaxation practice might be beneficial in containing stresses of this type of work. This along with encounters with some other political writings from a Buddhist orientation [13, 14], were part of my own early journey into contact with Buddhism.

Buddhist meditation techniques emphasize the importance of a concept known as "mindfulness". To illustrate the centrality of this concept: a story is told of the Buddha being stopped on the road by a group of soldiers who were going to battle, telling him they might die that day and needed to know what teaching he could give them that was at the core of his spiritual lessons. He is said to have replied with one word: "awareness". Meditation techniques, by encouraging the strengthening of the capacity to focus single pointedly on an

indicated object, with the gentle but progressive development of self accepting strategies for dealing with intrusions on that concentration, provide important resources for the clinician in dealing with the at times bewildering array of influences and stresses that confront us in clinical mental health practice. Also within Buddhist practice are extensive techniques for cultivating positive attitudes towards others. I remember encountering as a trainee psychiatrist the Rogerian proposition that "unconditional positive regard" was a desirable feature to be cultivated by an effective therapist. However, this was in the context of not being provided with any very clear directions as to how to develop such a desirable state. Buddhist teachings and meditation aspects have their place here.

Buddhism as a Source for Therapeutic Techniques

There has long been a degree of cross-fertilization of ideas between Buddhism and psychological therapies. There is a substantial school of Tibetan psychological strategies taught within Buddhism described as "thought transformation" trainings, [15] many of which have similarities with reframing strategies in cognitive restructuring and other cognitive behavioural techniques. A large number of mental health practitioners also make some use of meditative techniques and there is extensive evidence of their psychological helpfulness.

One recently published treatment manual illustrates well the potential for cross-over in this area [16]. In seeking to develop a maintenance form of cognitive therapy for depression, Segal et al. decided after going considerable distances up some blind alleys, that one of the key aspects of mental function they wish to promote in helping people maintain gains achieved during cognitive therapy was the ability to de-centre or distance from one's own thinking; the ability to look at it from an observing posture without being overly engaged with thoughts as the central definition of self. This they saw as an important vehicle in the ability of people to be able to apply lessons learned in cognitive therapy on a continuing basis. In their quest to find effective and cost effective ways of promoting such an aptitude, they found themselves exploring mindfulness-based approaches. This led to them completely revising their treatment directions and developing a package of mindfulness-based cognitive therapy for depression which integrated Buddhist notions of mindfulness and mental awareness with western notions of cognitive therapeutic techniques. This was then manualised, trialed, and showed good outcomes, particularly with people with multiple depressive relapses. This whole exercise was funded by the National Institute of Mental Health in the USA.

CONFLUENCE AND CONFLICT

It seems clear then that there are a number of points where there may be confluence between Buddhist thinking and Western psychology and mental health practice. Many of the accessible and now – thanks to a wide range of translations - readily available presentations of Buddhism will provide material that will be of relevance as a resource in cognitive and behavioural therapeutic settings. Buddhist techniques have a role in collaborative work on understanding of the nature of mind. Practitioners may benefit from the mental stability and awareness developed through meditative practices, and others are likely to find their own sources of convergence that I have not presented.

We might now move onto some of the areas of difference. In traditional presentations of Buddhism, there are teachings which are open (exoteric) and teachings that are secret (esoteric). The teachings so far alluded to are substantially within the open group; within the traditionally secret group are in-depth teachings on "emptiness" and also most of the teachings of tantra. Here we might find some of the divergences.

Tantric techniques involve among other things extensive use of visualization practices and these are something which generally receive little attention or exploration in Western clinical mental health practice. Teachings on "emptiness" may seem to stand at odds with many of the tenets of cognitive therapy. Within cognitive therapy, the negative automatic thought is often presented as something to be faced, engaged with, addressed, challenged, debated, and thereby overcome. Beginning with mindfulness teachings but then developed further with notions of emptiness, Buddhism suggests different routes than these to dealing with negative thoughts. In emptiness teachings, the nature of selfhood is explored closely and in depth; the features of the self, including thoughts are seen as "dependant arisings" - products of causes and conditions and not with inherent existence.

Mindfulness traditions in meditation encourage that troublesome thoughts can be simply allowed to pass, and not necessarily engaged with on their own terms. Emptiness teachings go further than this, promoting the ability to respond to such thoughts by invoking the understanding of their essentially impermanent, conditioned, and evanescent nature. In this respect the invoking of emptiness to deal with frustrating or distressing thoughts does not involve engaging with the thoughts and grappling with them; rather, it involves applying a particular mental posture to the experience of a thought, in response to which the distress associated with the thought is undermined, by the application of an attitude that holds that this troublesome thought really has no existence. The full fruits of the experiential

understanding of emptiness is a far from easy thing to achieve. I would certainly not claim it.

However, even in partial forms, the use of the concepts and the reflection on them as antidote to adverse situations can be powerful. Emptiness is one instance where, to my understanding, Buddhist thought would diverge from most applications of cognitive therapy. Indeed, Buddhism may be in some degree of tension with any psychological therapy which works in modalities that strongly intensify the notion of a sense of self and selfhood. The Buddhist approach may be described as rather generating a more diffuse and distributed, looser sense of self which, in turn, is seen as freer, more flexible and more spacious than is a self identified as local, enduring, and inherently existent.

As noted in the introduction, Buddhism is Australia's fastest growing religion: a lot of this growth is in new converts to Buddhism among previously non Buddhist Australians.

Increasingly people working in clinical practice may encounter Buddhists including Buddhists of Australian origin. As with any of the many cultural settings of practice, it may be important to understand the cultural context when conceptualizing their problems. This may have particular importance in Buddhism where the nature of the cultural content has so much in the way of material that is closely related to the application of psychological techniques. This paper can only have scratched the surface on an enormous set of topic areas. Presented here are some suggested areas of convergence and divergence between two substantial bodies of thought and practice. Others may find that parallels or distinctions I've attempted to make are not persuasive, and there are often multiple valid ways to present the kinds of concepts referred to in the paper. If this is so, I at least hope that this contribution will serve to promote discussion and debate about the areas of common ground and constructive collaboration between two very important traditions of philosophical and psychological thinking, and their associated bodies of practical psychological techniques.

Acknowledgement

Thanks to the Venerable Ivan Milton BBSoc, MPsych. for helpful comments on an earlier version of this paper.

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Appendix Five

Australian Mental Health Umbrella Organisations

Central Govt Dept of Health and Aging www.health.gov.au

Dept of Health and Aging consumer health info www.healthinsite.gov.au

Australian Central Government Mental Health Strategy
<http://www.mentalhealth.gov.au>

Mindmatters : <http://online.curriculum.edu.au/mindmatters/index.htm>

Mental Health Foundation, Australia.

Web-site : www.mhfa.org.au

Email : mentalh@mira.net

World Health Organisation

Atlas on Mental Health info world-wide : <http://mh-atlas.ic.gc.ca/>

or search on Google for mental health atlas

User contacts

peoplewho.org

wnusp-suscribe@topica.com

Hyphen-21 – www.charts.force9.co.uk

*Conference Notes by
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