

SYNOPSIS OF WORKSHOP ON 16TH JULY

I. Introduction; Aims of the Workshop; The Setting; The Program; Breakdown of Participants; Aims of This Report.

Background and Aims: Diagnosis in psychiatry has never been very satisfactory; dissatisfaction is expressed in various ways by different groups, whether scientists, mental health professionals, or concerned people from the wider community. In the past, dissatisfaction could be hidden, because psychiatry itself was often a hidden, secretive profession, closely linked to the existence of large mental asylums, generally kept remote from public scrutiny. Today, with improved treatments, better understanding of many mental disorders, better awareness of the terrible harm often done by the asylums, and increased emphasis on human rights and ethics, the face of psychiatry is changing. Psychiatrists are reaching out to the communities they should be serving, hoping to establish a relationship of trust and respect, as has usually been the case in other areas of medicine. Given this, the subject of Psychiatric Diagnosis is a prime area for discussion, an area where the most fundamental issues about psychiatry, and the most practical ones are jointly in play, an area where professionals of many types, and concerned people from the wider community are all essential players in any debate. With this in mind, the idea of bringing together the diverse stakeholders in a broad-ranging discussion of the complex and troubling issues about psychiatric diagnosis began to take shape.

Two circumstances gave impetus to the idea. *First*, we learned that Professor (emeritus) Allen Frances, of Duke University, North Carolina, was visiting Australia in July 2012. He headed all the committees which put together the DSM-IV (Diagnostic and Statistical Manual, fourth edition) of the American Psychiatric Association, published in 1994; and, as the fifth edition (DSM-V) is soon to be published, he has become a vocal public critic of the new document, especially of what he sees to be “diagnostic inflation”. *Second*, the mental health advocacy N.G.O, *Kites Trust*, saw the merits of a workshop with Allen Frances as a keynote speaker, and was prepared to underwrite the costs of bringing him over to New Zealand. We were thus able to work together to plan a workshop on Psychiatric Diagnosis, as a one-day event in mid-July, to suit Allen Frances’ travel schedule.

Priorities: In planning the workshop, several priorities were kept in mind. Uppermost was the aim to have a 50/50 split between mental health professionals of various sorts and community people (activists, spokespersons, those with lived experience of mental disorder, caregivers and family members affected by these disorders). To achieve the right balance, this priority was explained in initial publicity, and potential participants were asked to say which stakeholder group they belonged to, with final decisions over who would be invited to be based on getting a good balance. In addition, it was important that the workshop should allow plenty of time for wide-ranging interaction and discussion on the complex issues involved, rather than having a program dominated by scheduled speakers. The program which emerged had most scheduled speakers in the morning, with more time allotted to open discussion as the day progressed. Lastly, it was intended that the number of participants at the workshop should not be too large, since this would have changed the

character and openness of the discussion. The conference room available at the Brentwood Hotel in Wellington was suited for up to 80 people, and in the end, most places were filled.

Participants: There were 73 whose affiliations we could identify, plus a few more we could not identify. They included:- 7 psychiatrists (including the keynote speaker, Allen Frances, the Director of Mental Health, John Crawshaw, and Professor Graham Mellsop); mental health nurses (4); Clinical psychologists (2); mental health team leader/service manager/operations manager, including one leader of an early intervention team (8); Ministry of Health policy developer (1); GP/mental health coordinator in primary care (2); social worker (1); “Tutor”: (1); 13 who identified themselves as “consumers” (who almost all had additional roles: consultant-contractor-advisor [8], researcher/neuroscientist [3], patients’ rights advisor [1]); Maori mental health specialist [1 – unable to be present on the day]; lawyers/District Inspectors for Mental Health (2); Family members (4 – one also working in an NGO); Staff in mental health NGOs (9 – 3 as managers/leaders, 1 as a research evaluator, 1 as family/*whanau*¹ worker); Members or coordinators in the government-sponsored “*Like Minds Like Mine*” anti-stigma program (7).

The *Program* ran as follows.

9.00 a.m: Maori Welcome by **Tane Rangihuna**

9.10 a.m: Opening the Workshop. **Dr John Crawshaw**, Director of Mental Health, emphasized both the merits of psychiatric diagnosis, and the dangers if not applied correctly.

9.20 a.m: **Robert Miller** spoke next, for 20 minutes, with the title *Psychiatric Diagnosis in the Context of the History of Science*. This gave a historical context to our workshop, but also emphasized current problems from a community perspective.

After a break for tea/coffee, the next speakers were community spokespersons, two from the *Like Minds* team in the Wairarapa – **Daniel Real** and **Julie Channer**, both with lived experience of serious mental disorder, and now vocal contributors to the anti-stigma program. The third speaker here was **Virginia (Ginny) Port**, from Hutt Valley, who spoke as a parent of a daughter with a complex on-going problem.

11.00 a.m: **Professor Allen Frances** spoke and engaged with all other participants for the next 80 minutes, speaking without notes, in a fully interactive way, fielding questions from all-comers, and sometimes referring to his Power Point slides on the theme of diagnostic inflation, but not as a prepared speech. In the last ten minutes of this session (before lunch) the other speakers in the morning’s session joined him as a panel, to respond to questions on their own presentations.

12.30 p.m: Lunch

1.30 p.m: **Professor Graham Mellsop** spoke, giving his perspective on diagnosis, how the last forty years was a “history of *no progress*”, and also giving a wealth of empirical data from researches conducted by him and his colleagues, on uses of, and attitudes to psychiatric diagnosis from different professional and community stakeholders. This session included time for discussion.

¹ For non-New Zealanders: “whanau” (pronounced: fah-now), Maori word, meaning “extended family”.

2.30 p.m: The next session included four brief presentations: **Mike Sukolski**, a consumer advisor (mental health) within Hutt Valley District Health Board. **John Edwards**, is a lawyer with close involvement in investigation of abuse claims in asylums, and in negotiations over compensation (and now a District Inspector for Mental Health). **Helen Rodenberg**, a Wellington-based G.P. spoke of dilemmas in her practice, over whether or not to give a diagnosis. **Kate Diesfeld**, also a lawyer and District Inspector, spoke of how the Mental Health Act was used, and how diagnoses have influences in many other ways, often unhelpful.

After a break for tea/coffee (3.30pm), our final discussion (facilitated by **Tane Rangihuna**) had, as prompts, the following questions: “Can a single system of diagnosis serve the interests of all stakeholders?” “If not what are the alternatives?” “Putting learning into action – how will what we have heard today change the way we think, respond and work” and “Where to from here?”

Feedback-Evaluation: After the workshop, participants were invited to complete a feedback/evaluation form, which allowed plenty of space for free comments. It also asked those responding to identify which stakeholder group they belonged to. Comments received are summarized towards the end of this report.

Synopsis of emotional tone at the workshop; and aims of this report.

At the workshop itself, and in the feedback/evaluation forms there a vast diversity of comments on diagnosis were made. The following points give an indication of the style and tone of the workshop.

First: Everything that was said was based on first-hand experience, whether as a clinician, one with lived experience of illness, a caregiver, or in other ways. This fact assures participants of the validity of everything that was said.

Second, in the discussions themselves, and in feedback comments, there were some expressions of dismay and doubt that it would ever be possible to reach a consensus. However, if everything that was said has the validity of first-hand experience, apparent differences of perspective cannot be true disagreements, but different parts of a complex kaleidoscopic picture. There was little (if anything) that could be identified as real disagreement, at an emotional level.

Third: The records of the workshop included the text of some of the presentations, Power Point slides from two of the presenters, notes taken by various people assigned to the task (which was especially helpful for discussion sessions), plus notes and personal recollections of the day by the author of this report. From these sources a longer report and commentary on the workshop has been written. This will be made available on the website of *Kites Trust*, and that of the author of this report (www.robertmiller-octspan.co.nz).

Fourth: The longer report quotes extensively from remarks made at the workshop, but also incorporates material additional to that presented at the workshop, including publications of some of the scheduled speakers. It starts with an overview of the workshop, leads into the perceptions of participants on the advantages of psychiatric diagnoses, the inadequacies of diagnoses in practice, fundamental flaws which may exist in the process of psychiatric diagnosis, and the dangers which commonly derive from misuse of diagnoses, or are inherent risks deriving from their fundamental flaws. Towards the end of the commentary, suggestions are made of possible remedies for problems with diagnosis, how

to retain the benefits yet avoid the weaknesses and dangers of diagnosis, and how to move towards resolving the most fundamental problems. Any conclusions reached, or recommendations made, in that full report, should be seen as matters for open discussion, not definitive statements.

II. Details on Presentations of Scheduled Speakers

Dr John Crawshaw opened the workshop with the observation that, when we are faced with complex data, we seek patterns, and have to label them. This is basic human nature. We cannot avoid it. To put labels on supposedly different classes helps us to organise confusing impressions. There are two approaches to this: We may put names on specific entities which seem “prototypical” of a larger class though not identical to any instance of it; or we may look to split up all those entities into sharply separated categories. Psychiatry has tended to use the first of these approaches. The legal profession, on the other hand, sometimes dealing with the same human beings and the same conceptual issues, generally prefers sharp categorical distinctions.

Classification can be of major assistance, and diagnosis is important in psychiatry, but labels should be used discretely. Ideally a diagnosis should give guidance on what can be done to help a person; but we must avoid unnecessary pathologising by use of such labels. Unfortunately, much of the time when we classify in psychiatry, we then impose a view of the world which unduly “reifies” and simplifies. To have a word for a class makes the class seem more solid and uniform amongst its members than is really the case in the raw data. It is thus easy to over-rate the value of diagnosis. By itself diagnosis seldom specifies exactly how a patient should be treated. Additional factors are needed for this, including his/her whole life story, personal strengths and weaknesses apart from the diagnosis, and current life situation. Using these matters as well as diagnosis to plan treatment is referred to as the “formulation”. Diagnosis is only the beginning.

Robert Miller spoke next, putting contemporary concern about psychiatric diagnosis in the context of the whole history of science. This subject bring together the hardest scientific questions in psychiatry with the most immediate practical concerns from mental health advocates in the community. People in the general community are concerned about inconsistency of diagnosis, its over-simple categorization of human nature, use of diagnoses to serve commercial ends, the stigmatizing impact of some diagnoses, and the potential for psychiatric diagnoses to become part of political manipulation of psychiatric practice. Underlying all of this is the insecure status of psychiatric diagnoses as scientific concepts. Using precedents from the early history of science, especially the study of planetary motion by Isaac Newton and others, Robert suggested the following maxim: *The **only** way in which scientific concepts can be securely validated, such that they will stand the test of time, is when they are defined in such a way as to support strong explanatory arguments.* Although biology, medicine and psychiatry are vastly more complex topics than the study of the motion of the planets, Robert suggested that it is now time to adopt the same approach to establishing concepts of mental disorder, using the sort of scientific reasoning which prevailed at the very start of the scientific tradition four hundred years ago. To adopt the style of the physical sciences in psychiatry in no way implies making psychiatry impersonal

and dehumanising, although Robert admitted that much of today's brain science can be criticised on just those grounds. In any case, mental disorders involve a complex interplay of biological factors and social ones (which will vary from time to time, and from one country to another).

Daniel Real works with the *Like Minds Like Mine* team in the Wairarapa, and is also a skilled radio interviewer (with John Kirwan amongst those he has interviewed). He described his own story, a complex one, dominated by mental health problems from childhood days. Looking back he thinks he was anxious all through childhood. At 18, as a student he had a psychotic breakdown, and soon after received a diagnosis of schizophrenia. Doctors kept increasing the dose of medication, and he stayed at home, drank coffee and smoked. Eventually he was discharged from mental health services, and later came off all medication. After that it took him ages to get to sleep, and he had frequent anxiety attacks. He ended up in hospital, had lots of tests, but remained off medication. At 26 he received the diagnosis of OCD (obsessive compulsive disorder), which he now realises he had had for many years. Then, from a neurologist, he received the diagnosis of Tourette's Syndrome². He was offered CBT to help with anxiety. Despite continuing to hear voices he stopped taking medication in 2003. (The medications continued to be prescribed for well over a year – and Daniel brought a year's supply of empty packets to show those at the workshop.) Now he rejects the value of diagnoses, at least for himself. His expertise for this workshop "comes from having had more diagnoses than fingers on both hands". He still hears voices, and is increasingly accepting of them, partly from his interaction with the "Hearing Voices" network. His quick mind, concise and strong ways of expressing himself, and sly sense of humour shone through even on this brief presentation.

Julie Channer also has a complex story, which she described. At age 19, as a student, she became acutely unwell and was committed to Porirua Hospital. The next ten years were a long journey through the mental health system. She believes that recovery is not possible with medications alone, but they may provide "a space to heal". In preparation for the workshop she had asked her parents what they thought of diagnosis, based on Julie's and their own experiences. Her father thought that Julie had been caught at the end of an old-fashioned era, when ways of diagnosing and treating were changing. Different professionals had different opinions, and Julie's diagnosis was 'softened' as time went on. No-one really knew what was wrong; it was a 'hit and miss' affair. "My father does not believe this to be an exact science". The word "schizophrenia" conjured up images from the movies: It was scary and ugly. A drug that works for one individual won't necessarily work for another with the same diagnosis. Although some medicines helped to 'settle me' (Julie said), much of Julie's recovery was her own achievement (father and daughter agree on this). Julie's mother had a more favourable view of diagnosis, saying that it gave a sense of certainty, and a guide to the best treatment. However, Julie had concluded that "it is not a diagnosis that is treated, but symptoms". Given that she had had several diagnoses, she preferred to ignore them rather than believe that they all applied to her. "With all the diagnoses I have

² OCD and Tourette's Syndrome are generally thought to be closely related, the former term being used by psychiatrists, the latter by neurologists.

received, am I really all that screwed up . . . or was it that the doctors just couldn't decide, and so kept changing the diagnosis?" Julie finished with strong words on the stigmatising effect of the schizophrenia diagnosis, especially in its adjectival form – a “schizophrenic” – handed out as if it were a life sentence. Overall she saw no benefits to come from diagnoses.

Virginia (Ginny) Port described the journey she had had with her daughter, over many years. The initial diagnosis had been schizophrenia, but combined with escalating alcohol and drug addictions, emotional instability and self-harm. Other diagnoses had included Post-traumatic Stress Disorder and Anxiety Disorder. Four years before the workshop the diagnosis had settled on Borderline Personality Disorder (BPD), and this had helped greatly, leading to Dialectical Behaviour Therapy, which had proved useful. However, other people to whom Ginny had spoken found the BPD diagnosis stigmatising and unhelpful, and they tended to deny the diagnosis. Ginny also wondered if this diagnosis might become a “self-fulfilling prophecy” for some, giving them license to behave in ways they would otherwise avoid. Ginny was particularly concerned about mental illnesses starting when young adults were in tertiary education, with all its social pressures. She was well aware of how difficult it is for psychiatrists to make a diagnosis, to get at the truth despite attempts at concealment, and she understood their unwillingness sometimes to give a diagnosis which was likely to lead to stigmatization. Although communication with professionals had been difficult early in her story, there had been big improvements in recent years, and better understanding of cultural differences. She also recognised that much of the day-to-day communication with consumers was with mental health nurses, rather than psychiatrists.

Keynote Speaker: Professor Allen Frances

(This synopsis is based partly on notes taken on the day, partly on Allen's Power Point slides. Some of his comments are clearly based on USA experience, but he had some important statistics for New Zealand, was listening hard, and asking hard questions about New Zealand and Australia. The full report and commentary includes some discussion of what he said. He spoke without notes in a fully interactive way, with much dialogue with the audience.)

Linking to John Crawshaw's introduction, he began by noting that it is human nature to label things – labels *can* help but they can also destroy (people). He asked: How do we favour the former and avoid the latter?

In the USA, diagnosis was a joke before 1980, with no consistency of diagnoses, no common language. DSM-III provided a common language, not without its weaknesses, but arguably better than before. However it soon became too important, and unaware of its limitations, and that, beyond the diagnosis, there was a *person*.

Allen spoke strongly about diagnostic Inflation, especially with regard to childhood or developmental abnormalities. Today, in any one year, 20% of the US population gets a DSM diagnosis, 50% across a lifetime. A new US study has reported that an amazing 83% of young people meet a DSM-IV diagnosis by age 21. In Europe the lifetime risk of any disorder is 43%. In New Zealand by age 32, the risks for anxiety disorder was 50%, mood disorder 40%, substance dependence 40%. There has been an unnecessary manufacture of

psychiatric epidemics: of ADHD (3-fold increase since publication of DSM-IV in 1994), autistic disorders (20-fold increase, partly resulting from the inclusion of Aspergers disorder within the autism spectrum), PTSD, bipolar disorder (with 2-fold increase, especially childhood-onset bipolar disorder: with a 40-fold increase)³.

Diagnostic inflation is driven partly by pharmaceutical companies, with aggressive drug company marketing direct to MDs, direct advertising to parents (and for ADHD – to teachers). This applies particularly to ADHD and childhood bipolar disorder, and to new on-patent drugs. Most of the companies' finances go into marketing and related legal costs, not research; and many so-called "new" drugs, are "me-too" drugs, slight modifications of pre-existing medicines, which allow prolongation of patent life, but with little real research-based innovation. U.S.A. and New Zealand are the only countries that allow direct to consumer marketing of medications.

As the importance of diagnosis became exaggerated, its original purposes came to be distorted by the administration dependent upon it. So, since an autism or ADHD diagnosis was needed to obtain support from school services, there was pressure on psychiatrists to make these diagnoses. "There was too tight a linkage of the diagnosis to the eligibility for school services". Since a PTSD diagnosis was needed for health insurance payments, there was likewise pressure on psychiatrists to make this diagnosis.

Severe mental illness can now be diagnosed fairly reliably, and after diagnosis, fairly good treatment is usually available. However in the U.S.A. there is now massive over-diagnosis of people who don't need it (the lesser disorders), but lack of attention and care for people with severe disorders who do. One third of people with severe depression in the US are never seen by a professional. There has been a diversion of attention from people with moderate to severe mental illnesses to the larger number with milder issues. "There is too much psychiatry, but we are missing severely ill people". For some of the less severe diagnoses (eg ADHD), the boundary with normality is fuzzy and slight adjustments to diagnostic criteria make vast differences to reported prevalence. Addition of "bipolar II" to bipolar I in DSM-IV contributed to the increase in prevalence, as did the fuzzy boundary with unipolar disorder. For minor disorders, Allen asked "Why do people stay on medications?" Part of the answer, he implied, was that for milder disorders, placebo responses to medicines are much more common than for more serious disorders.

Diagnosis is often difficult even for adults, becoming increasingly problematical for adolescents and especially for children. Early diagnosis makes little sense because of the excess of false positives. The younger the person, the harder it is to diagnose accurately. For teenagers in difficulty, it makes no sense to be too certain about diagnosis. Allen was seriously concerned about mental health assessment of pre-schoolers, this concern being specifically referring to New Zealand and Australia. "Diagnosis of pre-schoolers" is crazy, he said. He was worried about how part of New Zealand's system for health assessment of

³ Some discussion of these statistics is given in the full report and commentary on the workshop. Here the aim is limited to reporting what was presented on the day.

preschoolers (“B4School”) becomes in effect a pre-school mental health assessment, which is now being considered for use, nation-wide, across Australia. Allen was also concerned that, when diagnostic criteria are changed, there is increase in childhood prescribing of antidepressants. When B4School was introduced in New Zealand in 2009, use of antidepressant drugs in children increased. He said that every diagnosis in a young person should be temporary, not permanent. A diagnosis should only be given when clear and necessary. It is only a small part of the process and it has been given too much power; but we should not dismiss of the importance of diagnosis.

In the USA “problems of living” are being transformed in DSM-V into psychiatric disorders. For instance, in DSM-IV the distinction between normal grief after bereavement and extended grief reactions was made in terms of duration of depressive symptoms, and severe reactions such as suicidal behaviour. In DSM-5 the distinction will be lost, since the cut-off point between normal and pathological grief will be depressive symptoms lasting only 2 weeks. Likewise for “major depressive disorder” the criteria have been relaxed to the extent that it is now “no longer either major, depressive, nor a disorder”. Normal anxiety become GAD; Anxiety mixed with sadness becomes MAD. Temper tantrums become DMDD, Binge eating become BED, forgetfulness of old age becomes MNCD, teenage eccentricities become APS.

Summing up, Allen asks: Is anybody sane here? The border with normality is fuzzy with many people in that border zone. Small changes in criteria create millions of patients. DSM-V will medicalize the stresses, worries and disappointments of everyday life. The pool of “normal” shrinks to a small puddle, and this creates the impression that we live in a sick society. “For psychiatric diagnosis Murphy’s law applies: If something *can* go wrong, it will.” It is easy to give someone a diagnosis, but very difficult to undo the process; yet it may have lifelong impact.

The *Discussion* which followed, raised many points, and a complete record is not available. However, they included these:

One consumer advocate raised the issue of whether the switch of psychiatry to primary health care was a good thing, and if not, what should be done about it. “GPs are usually not so good at diagnosis, and do not have so much time as specialists.” Allen made the point (presumably about the U.S.A.) that primary care MDs prescribe 80% of psychotropic drugs, but have little training or interest in psychiatry, and little time to evaluate symptoms or history. They tend to favour pill solutions, are easily influenced by drug companies, “‘opinion leaders’, and patients.

A Wellington GP agreed with the statement by Allen that there are people who need to be, but do not get diagnosed. She did not believe that there was diagnostic inflation in New Zealand, and felt the danger of excessive direct marketing was less than in the U.S.A. Another speaker suggested that diagnostic inflation was not unique to psychiatry, but had been occurring for some time across medicine, driven partly by the trend towards “defensive medicine”, with excessive safety concerns to avoid litigation. She felt that, at least in the U.S.A, this trend was reducing, with fewer (probably unnecessary) tests. In psychiatry, Allen Frances felt that diagnosis was less important to patients than to other stakeholders.

Some service users at the workshop criticised the way diagnoses stereotyped people, rather than acknowledging their unique characteristics. However, a trainee psychiatrist spoke in favour of diagnoses, insisting that, for her, the stereotypes of a “prototypical classification” are needed to simplify things, at least as a start. One consumer spokesperson spoke strongly in favour of receiving a diagnosis (referring to people she knew). However, another spoke against the whole concept of diagnosis, regarding DSM as “A book of insults”. She thought we needed a concept different from diagnosis, asking: “Is there another framework, which acknowledges our experiences and is not stigmatizing”.

The writer of this report followed this up by pointing out some important differences between mental illness and other forms of illness. For mental illness, vulnerabilities and weaknesses may be inextricably linked with positive things – advantages over normal, even exceptional talent. This leads to a different model, with precedents from work by educationists. There a sharply-categorical grading system has been used (for instance, for university degrees: “First class, 2.1, 2.2, 3rd-class”). There have however been attempts to develop the idea of a “qualitative transcript” which is more informative and helpful, and which encapsulates both strengths and weakness.

After lunch, the program continued with another invited speaker:

Professor Graham Mellsop divided his talk into two parts.

The first was a semi-historical review of the history of attempts to formulate diagnostic systems since the 1970s. “Between the publication of DSM-II in 1968 and DSM-IV in 1994 (or between the publication of ICD-7 in 1957 and ICD-10 in 1992) the number of diagnoses has increased ten-fold, but gains in predicting prognosis, in management planning and in understanding causes are all questionable” he said. The 1970s were “a period of great hope and optimism”. Robins and Guze (1970) proposed five types of information upon which classification systems should be built – clinical features, pathogenesis (that is basic cause), clinical course, incidence in relatives and investigatory markers. At that time the directions seems clear. New treatments were thought to target specific diagnoses and research techniques for investigating the human brain were advancing rapidly. However, in the last ten years this confidence has faded. Many diagnoses can be treated with a variety of approaches, cutting across the early distinctions. It could no longer be said so easily that a diagnosis was an accurate guide to treatment. A person who fitted the criteria for one diagnosis very often fitted those for another (or several). Despite the supposed objectivity of diagnosis, most clinicians had favoured diagnoses, and, over the years of a person’s illness there was often inconsistency of diagnosis. The criteria for diagnoses could be used flexibly, and this had sometimes led to popular epidemics (Aspergers, ADHD, delayed PTSD, Dissociative Identity Disorder, and a variety of personality disorders which Graham referred to collectively as “the unlikeables”). Underlying all of these problems was the issue of whether mental disorders should be classified as separate categories (like infectious diseases) or as extremes of continuous variables (or “dimensions”), as is the case for blood pressure and hypertension. Graham conceded that the imperfections of our classificatory system were widely recognised, but the psychiatric profession appeared reluctant to commit to move on. *In short over the forty years since Robins and Guze, there had been little progress.*

The second half of Graham's presentation dealt with evidence he and his colleagues had collected about how various professional and community groups viewed current diagnostic systems, how they used them, and what they wanted from improved systems. Some of this research has broken quite new ground, with no parallel studies elsewhere in the world. The groups he has studied include psychiatrists, clinical psychologists, community psychiatric nurses, G.Ps, social workers, caregivers and service users. Full details of these studies, based partly on Graham's Power Point slides and his publications are contained in the full report and commentary. Here a few of the highlights are mentioned:

Psychiatrists: The officially-recommended diagnostic system in New Zealand is ICD-10, but most psychiatrists use DSM-IV, because that is the system they were trained with. The systems are used mainly for communication between clinicians, rarely for communication between clinicians and their patients (although many psychiatrists seems happy for patients to use the systems, presumably without expert guidance). Very few used the systems to indicate prognosis. They were difficult to apply trans-culturally, and a substantial minority of psychiatrists thought they were too strongly influence by European cultural concepts and values. Most psychiatrists would prefer a system with less than 100 diagnostic options (compared to 400+ in DSM-IV).

Clinical psychologists like psychiatrists mainly used DSM-IV, this being used for communication amongst themselves. However, psychologists apparently relied on the system more than psychiatrists for communication with clients, to inform management and to indicate prognosis. They would prefer a classification system to be a better guide to their practice, and to consider cultural identity. *Mental health nurses* used the systems for purposes similar to clinical psychologists, but also to access specialist services and to help make decisions about admission and discharge of patients.

G.Ps rarely used the official systems, seeing them as too complex, irrelevant to their own practice, and requiring training they did not have. While the majority of both G.Ps and psychiatrists, when asked, thought they should both use the same system for diagnosis, the differing nature of their work makes this hardly practicable.

For caregivers and service users, the methods of collecting data were different from those used for the various professional groups, and results were not presented systematically. Attitudes of these community groups are best understand from other parts of this report, and from the full report and commentary.

The next session of the workshop included a panel of four presenters, each speaking for 10-15 minutes.

Mike Sukolski, drew an analogy with literary theory between the *story* and the *plot* of a novel, the former being an account of events in chronological order, the latter, as reconstructed and given significance and meaning by the author of the novel. In psychiatry, it tends to be the psychiatrist, not the patient, who is the "author".

“The storyteller is the diagnosing clinician, and not the person undergoing assessment. This is the root of the problem: The person undergoing assessment is not granted, must not be allowed, the *authority* of their own story. . . .Yes indeed, someone is plotting! And it isn’t me. The story is mine; that much I grant you; but what is this? Could someone be plotting *against* me? . . .In whose mind does the meaning of my story dwell?” He suggested that “the way forward will be, and can only be, through creation of an inter-subjective space in which the diagnosing clinician and the person undergoing assessment can come each to approach the other. It is a necessary *inter-dependence*, a *mutuality-of-interest* that must be vigorously entered into, unequivocally endorsed, resolutely defended.”

John Edwards, (a lawyer, District Inspector for Mental Health) started by explaining that when psychiatrists make a diagnosis, they are making a decision about a person’s state of mind. In this, “abnormality” is not just “statistical deviance from the norm”. However, entry into the mental health *legal* system does not depend on having a diagnosis. (This fact surprised a number of service users at the workshop.) Instead, use of the Mental Health Act requires a set of *defined observable behaviours* to be fulfilled. Speaking more generally, John’s experience was that many people were relieved when they got a diagnosis. It meant that someone else was relating to their story. They might even crave a diagnosis. However, he wondered whether consumers were giving too much credence to a diagnosis. He said: “From my point of view I see diagnoses as quite important: Courts like things to be nice and neat in boxes. However, I am less interested in diagnoses than in individuals’ right to have appropriate treatment. Some patients want to undo diagnoses made 10-20 years ago. The fact that someone made that diagnosis at that time remains a piece of history.”

Helen Rodenberg, a Wellington-based G.P. spoke of the continuing dilemma in her practice over whether to label or not: For example: ADHD:- To diagnose or not? Will it help or hinder children reaching their full potential? Dementia:- Should I tell someone they have dementia or not? If they are only mildly impaired, perhaps not – but we have to be careful. In general practice we do not make much use of ICD-10 or DSM-IV, but use other criteria. Has this person been in with this problem before? We may be more concerned about things that may help, such as good nutrition and exercise. So when we make a referral, we may seem quite vague. Referral to secondary services usually means moderate to severe mental illness; but to decide whether to refer depends not only on diagnosis. We have to take account of life events. So, people with moderate to severe mental illness are not necessarily referred to secondary services; and in any case sometimes the referral is not accepted.

Kate Diesfeld, also a lawyer and District Inspector, spoke of how the Mental Health Act was used, and how diagnoses, although not officially required for use in this Act, have many other influences, often hindering a person’s recovery or reintegration after a period of illness. To receive a psychiatric diagnosis impacts upon a person’s sense of self and identity, and influences their hopefulness for the future. She spoke of how novel diagnoses seem to be “invented” (sometimes for other than clinical reasons), and the risk of diagnostic inflation and “therapeutic creep”. Sometimes this amounted to pathologising conduct which is better defined in terms of its being socially unacceptable (e.g. “hubris syndrome”). Sometimes it served quite separate political agendas (e.g. solastalgia, created “to give

greater meaning and clarity to psychic distress caused by environmental change”). Kate was also concerned that “an increase in the number of recognised psychiatric diagnoses may have substantial personal, social, political impacts. These include the potential for the state to expand its coercive power over people who are deemed to have a psychiatric diagnosis.” Many debates centre on tension where law and psychiatry intersect. “Disciplines of law and psychiatry have distinctive philosophies, goals and foundational concepts. Sometimes they collide. Perhaps a common ground is to inquire what supports people want on their journey of recovery, instead of focusing on diagnostic labels.”

III. Synopsis of Question and Discussion Sessions.

The last hour’s discussion was reconstructed one month after the event from notes taken by several participants. Understandably, the points made did not follow a very logical sequence, and were not recorded in detail. Here the discussion is organized around several themes. The comments are far from a complete record, and many require clarification. Further discussion on some of the point raise is contained in the full report/commentary.

There are both benefits and dangers from diagnosis. There was widespread, near unanimous appreciation that the use of diagnoses in practice may be inadequate; and that dangers as well as benefits may flow from psychiatric diagnoses (and from widespread adoption of official systems of diagnosis). The potential for real abuse based on diagnoses was recognized by many. Some service-users spoke of benefits of diagnoses they received. More (perhaps) spoke of harm done to them by diagnoses. Those speaking positively often spoke of less serious diagnoses they had received, those speaking negatively often referred to major diagnoses - especially schizophrenia - which are more likely to be the basis of stigmatization. There were a few exceptions to this pattern. In any case, it is important to find ways to avoid the dangers of diagnosis, or inadequate ways in which diagnoses are used, while retaining their benefits.

Value of diagnoses: The most fundamental and basic benefit accruing from using diagnostic terms, is to provide a language. *We think* mainly through the medium of language. Mental disorder is an area where new language is needed, and with which we all struggle. Words for diagnoses allow families and *tangata whaiora* (as well as professionals) to “put a name to the face of a disorder”, as one of Mellsop’s respondents put it. Without this, all concerned may feel that they are “fighting a fog”, or “chasing ghosts”. Diagnoses are also important for education of psychiatrists. They *may be* helpful in guiding treatment, but, whereas diagnosis for heart disease is a good guide to, it is not so valuable for this purpose for mental illness. But, one may also ask, is the language provided by diagnostic labels robust enough to bear all the weight put on it? Is there any value in new terms, if they serve to confuse and stigmatise, rather than clarify, and if nothing tangible flows from them?

Damaging effect of diagnoses: There was much heartfelt comment from service users about the damage caused by diagnoses. One service user said: “Diagnosis is not a good thing; it did explain his suicidal attempt; and turned him into a consumer (and gave him a job!), and a tough advocate for other down-trodden users. Diagnosis has enabled misuse of the mental health Act, and human rights being violated.” It was hard to receive a diagnosis

without feeling stigmatized. Hearing the diagnosis of “schizophrenia” was hard. Another said that her mental health problems would have been very different if she had not been given the diagnosis of schizophrenia to label them. It led her into an institutional environment where fear and control rather than care and kindness predominated. If openness and compassion could predominate anything would be possible. Another experienced consumer advocate insisted that it was a mistake to pretend that bad stuff is just in the past. “It is not. Bad things are still happening”.

Communication skills and conveying diagnoses. This was stressed by many people, as was the importance of the person, whatever their diagnosis: One person quoted Hippocrates: “It is more important to know what sort of person has a disease than to know what sort of disease a person has.” To convey a diagnosis sensitively, a whole lot of related information needs to be discussed. Discussing a diagnosis is a valuable opportunity for clarifying symptoms, but for patients and carers, this had to be in plain language, which often did not happen. In any case, formulation may be more important than diagnosis.

“Classification systems like DSM-IV seem like objective science, but if a diagnosis is to be conveyed sensitively, it becomes more the ‘art’ of medicine.” It is important for a psychiatrist to explore each person’s history in relation to past diagnoses – “where we have been, and where we are going to”. A psychiatrist mentioned how the style of practice was changing, and how this affected communication about diagnosis: “Patients are now more equal to doctors – they research their condition on google and the internet.” In all these processes, active listening was needed by clinicians. The tutor (clinician) may then become the learner, and the patient becomes the teacher. A person’s experience is the root, and the beginning of the diagnosis procedure. “Experts need to learn from people who are experts on themselves”. Daniel Real made a point which stuck in many people’s minds: “My cat came and sat on my bed when I was unwell. Listening is not hard: My cat can do it. So. . . treat me the same way that my cat does”.

A psychiatrist raised the most fundamental question: *What is being classified?* Is it the nature of human beings? . . .or diseases? . . . or the range of human misery and associated problems? “Attempts to classify diseases end up classifying problems and misery, which is very hard to do.”

Towards the end, the discussion focused on the question “Where to from here?”, and possible political action deriving from the workshop was discussed (summarized in section VII below).

One question used as a prompt for the discussion (*Can one system of diagnosis serve everybody’s needs?*) was left unresolved, but several participants at the workshop thought that the issues were too complex for full resolution to be reached. “Too many stakeholders.” “Too much of everything to find next stage. Allen Frances commented here that “there is no right answer. Diagnosis helps some people, and harms others.” On the issue of whether one system work trans-culturally, he mentioned the WHO study showing that the best places to be schizophrenic were where there is no Western medicine.

A comment received subsequently in an e-mail from Allen, about the discussion, read: “You managed to have all voices represented and perhaps can begin to help unify an otherwise very fragmented constituency”. “I thought the most moving moment was when one service user reluctantly admitted that the young trainee psychiatrist is the hope of the future - a meeting of the minds and hearts.”

IV. Feedback/Evaluation.

Thirty-seven participants completed the feedback form. In the interests of clarity, the comments received are grouped according to a number of themes. As with the discussion at the workshop itself, these comments are not fully formulated ideas, and further discussion around the themes raised is contained in the full report/commentary. However many of the comment took the discussion a step beyond what was said at the workshop, and showed deeper reflection.

The diversity of perspectives heard at the workshop, the openness, mutual respect and safety of the environment for talking in personal ways were widely appreciated. Clinicians were surprised to hear service users speaking so robustly and openly, and the service users likewise were surprised to hear clinicians being so open, accepting and self-critical. The selection of speakers, and the clarity of their presentations were widely praised. An administrator wrote: “The debate about the usefulness of diagnosis is more advanced than I had thought which is very reassuring”.

Questions were raised in the minds of clinicians (as of service users) about current use of diagnosis: “It has stimulated my thinking about how we do use diagnosis currently, and whether enough time and information is given to clients and families about its use. It has also led me to think again about our use of community treatment orders”. “Diagnosis is very clinically-based which I now consider is not consistent with the end users’ needs and a helpful capacity to advance to wellness”. Another comment stressed “the need to reduce the gap in how these systems etc are falling short/so divorced from the people they’re serving”. A peer support worker wrote: “Interesting to hear how little G.Ps use classification systems, and how much psychiatrists struggle with them”. Services users’ impression that “diagnosis is a very hit or miss process” was confirmed by comments from clinicians (for instance, “that psychiatric diagnosis is fluid, ongoing; but there are so many variations to the theme that it becomes confusing to consumers”). Although psychiatrists were well aware of the deficiencies of the diagnostic system it was noted both by them, and by service users that they felt caution about radical change. “They can’t extract themselves from the diagnostic framework.”

As in the final discussion at the workshop, many comments received on feedback forms, from a wide variety of stakeholders, were about the importance of active listening and the way in which diagnoses are communicated. “Bio-psycho-social-environmental: all of these together with compassionate listening skills will move this field of social service forward for consumers.” “More sensitivity needed with treating and formulation or diagnosis”. A caregiver wrote: “Look at the person more than the diagnosis. I have always done this as a carer. I didn’t realize that clinicians could also think this as well”. From a lawyer we heard: “Necessity of *hope*, regardless of ‘diagnosis’ ”, and this led to the question “How to instill

hope, regardless of diagnosis”. From an administrator-manager we heard: “Diagnosis is not the identity of people”.

The potential for diagnostic systems to be abused was referred to in several comments in the feedback forms, but usually acknowledged the benefits as well as the harms flowing from diagnoses. Many were seeking a balance point to avoid the harms yet retain the benefits. One clinician wrote: “Diagnosis can be hurtful and helpful”. Another wrote of his “feeling that although some people are happy with diagnosis, for others it is hurtful and lifelong, and therefore extremely important not to over-use, and to do so in consultation with person.” “Psychiatric diagnoses will remain fluid. I wouldn’t and it shouldn’t be cast on a stone. Consumers would either be grateful or hateful in knowing the diagnosis. But for as long as the community will accept them with full equality and try to erase the stigma, it will definitely lessen their emotional burden regarding their condition”. “Systems and responsibilities of psychiatrists are required to encompass a lot into classification; which is a great responsibility and hill to climb. Consumers have also a large hill to climb (possibly a more treacherous one) to negotiate the system produced. Getting the two together will make a system that will be ten-fold improved”.

Issues of power were raised in several comments, generally accepting the complexity of the issue. A consumer wrote: “The issue of power is in the hands of psychiatry, and this was not fully explored today, neither was the reality of madness”. Clinicians recognized the problems: “Working in partnership, instead of clinicians knowing ‘what’s best’ for clients all the time! – Partnership means that power is interchangeable.” “Balancing the power between professionals and people accessing services.” The theme of partnership came up in a number of other comments, an essential factor in resolving these issues: “Importance of different stakeholders working together”. . . “Work together in partnership across interface between clients and clinicians”. “We need to find ways to work collaboratively towards commonly shared agendas, while honouring our differences”.

One danger of over-use of diagnostic systems was expressed in these words by a psychiatrist: “Many external agencies require a diagnosis for positive and negative reasons (courts/insurance/access to treatment and denial of treatment). Do we have any control over this?”

Some feedback comments followed up the call made at the workshop for a new conceptual framework to replace current medicalized diagnostic systems. One clinician asked “how alternatives to the medical model might work. What would the ‘legal’ definition look like as a beginning place for building a framework and increasing communication and strengthening the recovery process? (thus assisting people to meet their greatest potential)”. Another clinician had sympathy with consumers’ views questioning the “illness” or “disease” concept of mental disorder: “I found the word ‘illness’ (mental illness) was used a lot. I believe in 2012 this approach is not acceptable and unreal. ‘Illness’ is not the correct idiom; it needs adjustment to be more truthful – like ‘condition’, ‘position’, ‘formulation’, ‘prosthesis’. This word ‘illness’ is also the reason for the over-use of the archaic word ‘patient’”. However, it was recognized that there were great difficulties in designing and using diagnostic tools with a different conceptual basis.

On the question: “Can one system meet everybody’s requirements?”, different views were expressed. One clinician wrote: “Seek a system that has validity and is respected by clients and clinicians alike”. However, another stressed the need to “be aware of a number of perspectives and constructs rather than just the clinician’s viewpoint. A bigger role for negotiation was needed”. An administrator/manager wrote: “Different solutions probably best suited to different purposes/stakeholders.”

Some comments focused on the process of change and the necessary style of discussion: “There will never be an all-satisfying solution, I think. However, there is always a place of making room for more understanding, respect and integration”. “Different people have different opinions and change will take a long time”. It was recognized that there is difficulty “Often difficult to engage in meaningful debate that is based on objectivity and science, when such a variety of perspectives are in the same room.” One comment asked: “How to continue the debate – moving forward, avoiding our own tendency to get stuck, and not move forward?”

V. Overview of the Strengths of the Workshop.

The workshop was widely appreciated by its participants, with many gratifying expressions of thanks. Positive responses included the following:

(i) *Diversity of contributions to the workshop.* The diversity of views expressed, and the openness and mutual respect shown by everyone at the workshop were widely welcomed. The safe environment for all participants (who sometimes spoke in quite personal ways) was praised by several of those responding in the feedback forms.

(ii) *Questions were raised over whether, with such diversity, consensus can ever be reached.* It certainly cannot be reached without sincere efforts at mutual understanding of each others’ views. A process of discourse was started on 16th July. How far consensus-building can go is a matter for the future. This report (and the accompanying full report/commentary) may be an important step in the process.

(iii) *The scheduled speakers.* There was general support for the selection of speakers, and the clarity and thoughtfulness of their presentations. In the feedback forms every speaker was singled out for praise by one or more of the respondents, and there were hardly any negative comments.

(iv) *Selection of participants other than scheduled speakers.* The first priority in planning the workshop had been to have a 50/50 split between professionals and community, and this worked well. The diversity of stakeholders present was generally appreciated, but some groups were poorly represented. In planning the workshop, it was not the intention to have major biases amongst participants. However, in view of comments received about poorly-represented groups at the workshop, the full report/commentary amplifies what was said on the day with published evidence (especially that from research of Graham Mellso and colleagues).

(v) “*Cross-fertilization*”. There was general appreciation from clinicians and health workers (who sometimes expressed pleasant surprise) of having such open and robust contributions from *tangata whaiora*; and likewise there were a number of expressions of surprise from the latter, that clinicians could be so open, accepting, and self-critical. This indicates that this workshop was a rare and valuable event, quite different in its power-relations from situations in which members of these two groups normally meet.

VI. Shortcomings Of The Workshop On July 16th

From comments received in feedback forms a number of shortcomings were identified in the workshop. Most were inevitable, given the way it was set up; but they should be borne in mind in planning any further workshops on this topic.

Sound quality for scheduled speakers was poor, especially for those at the back of the room. The original plan had been for presenters to speak from the middle of the long wall of the rectangular room, with a small number of broad arcs of seating. This would have been a more “democratic” arrangement, and would have avoided problems with sound. However a decision was taken late in the day to move to another room, where this arrangement was not possible, and presenters had to speak from the front of the length of the room. Back speakers would have been an improvement, but we didn’t realize there was a problem until too late.

Several people asked for *certificates of attendance*, a matter which has been addressed by staff at *Kites Trust*. A clinician/health worker wrote: “Important that a certificate be produced in building up a portfolio, so that consumers know we health workers are at least attempting to understand this subject”.

Some groups were not well represented at the workshop, with few psychiatrists, or mental health nurses attending, few clinical psychologists, lawyers or administrators, no-one from Ministries of Social Development or Justice, and no-one concerned with the financial side of mental health services. There were far more service users than family members/caregivers. Nevertheless the primary objective of having a 50/50 split between professionals and community people was largely met. Related to this a comment, from an administer/manager was: “To some extent the workshop was attended by the ‘converted’. Would have been more interesting/challenging if more pro-diagnosis people attended. Not sure how one encourages attendance by more pro-diagnosis people”

Another comment was: “I did have some feelings of (dare I say) hopelessness with regard to whether discussions like these will have any effect on changing the system that is currently used. This feeling was possibly enhanced by the lack of number of psychiatrists and mental health nurses present here today.” Other comments followed on from this: “Much was not new to this audience – e.g. personal stories about good and bad of diagnosis. The *Like Minds* research on labels could have been mentioned.” (This comment has now been followed up, and articles in the two *Like Minds* newsletters are incorporated into the full report.) From a mental health trainer, there was the following comment: “There seemed to be a lot of arguing about pro’s and con’s of diagnosis which could go on and on, but

ultimately not be resolved – perhaps not the most constructive use of time”. All that can be said in response is: “This workshop is just the start. We haven’t finished yet”.

A comment, from a clinician manager, asked for “more information about what DSM-V changes might be, and what implications they might have”. Another comment (from a clinician/health worker) said: “Yes! It was a good workshop and very mind stimulating! Please send us copy and notes on the presenters. It will be a good resource”.

In retrospect, the *feedback/evaluation form* could have asked for more detail on the groups to which people belong. Amongst professional groups the form used the umbrella term “clinician/health worker”, and did not distinguish psychiatrists from other clinicians.

This report (and the full report/commentary) will be circulated to all participants, and a number of other interested people, in both New Zealand and overseas.

VII. Where to From Here? Practical Suggestions for the Next Move.

Balance of Participants: In the 50/50 balance amongst participants we seemed to have hit upon a formula to be strenuously developed in future meetings. More than one consumer wrote along the lines of this comment: “Keep the discussion going – keep the psychiatrists attending, and get more of them”. Another wrote: “More from the psychologists’s view”. However, from a research evaluator (non-academic) we read: “I’d love to be part of future discussions. Consumer involvement is critical” “I think the client/consumer perspective is really important and I wonder whether person-centredness/consumer perspective needs to be a critical thread in further discussions about diagnosis and classification”.

For future forums the balance of participants might be varied on each occasion (either deliberately, or “just as it happens”), including encouragement of more psychiatrists, psychologists, lawyers and representatives from government ministries to participate.

Style of discussion: There were some suggestions that this could be improved in future workshops: Several people suggested that richer interaction might come by breaking up into smaller groups for some of the time, each of which mixed up different sorts of stakeholder. In planning the workshop, this possibility was considered, but finally was not adopted. That may have been the correct decision for a first workshop; but the discussion might progress further at later workshops if this suggestion was adopted. At the end of the workshop the author of this report summed the day’s events up as “chaos”, to which a comment was received in a feedback form: “from chaos comes clarity, understanding, respect, equality and more respect”.

Agenda for future forums. Some comments emphasized *core* items for the agenda of future meetings (relevant to most stakeholders); others were more specific, and perhaps not of such wide relevance. Amongst the former we heard from a clinician/health worker: “From this conference, I think there needs to be more sensitivity and clarity about what diagnosis is for, and its importance to individuals.” From a consumer/peer support manager we heard: “It would be good to have moved on from repeated statements of strong views and hear more ideas on what changes might be envisaged for a better future system or

perspective”. From a clinician/health worker we heard: “This is an evolving process.” He also asked: “How sensitive is it, especially to clients?” The answer to that question depends on the emotional tone at each meeting. As noted earlier, there was little disagreement at an emotional level on 16th July, so there may be little cause for concern. However, one clinician/health worker asked for future meetings to “explore more about core beliefs and attitudes of participants”. That may be more challenging for all. There was also a call, from a clinician/health worker for “discussion around individual concerns re diagnostic criteria in greater detail”.

Amongst the more specific issues mentioned in feedback forms were: “More on culture”; From consumers: “It would be good to have forums on: medication; compulsory treatment”; “Hold a workshop like this for consumers/*tangata whaiora* so they could ask questions to the professor”. Some of these topics go beyond the subject of diagnosis, and require forums to be set up in a different way. Obviously Allen Frances had inspired the confidence of consumers, but we should all realize that it was our great good fortune to have him at our workshop on the 16th, and this cannot be easily re-arranged for a future date.

Political initiatives: If another workshop is to be run on a similar theme, it is important to try to get it accredited as Continuing Professional Development by RANZCP. This would encourage participation by psychiatrists or trainee-psychiatrists. A lawyer wrote: “Important to get critical psychiatry perspective debated in all New Zealand hospitals, clinics, medical schools.” A clinician/manager wrote “I would be interested in hearing more about the role of diagnoses, and for discussion similar to today being conducted in mental health services, because this might mean that how diagnosis is actually used (or not used) may be able to be changed.” Lastly, a consumer wrote advocating “adopting these discussions into clinical training with registrars”. This is a timely suggestion, since RANZCP is about to launch a new training program for psychiatrists. John Crawshaw, who opened our workshop is also the Chair of the RANZCP Board of Education, and the author of this report is the community representative on that Board. It will be mentioned at its next meeting, scheduled for 8th/9th November.

A research evaluator (non-academic) wrote: “Support Allen Frances’ call to influence politicians. How can we band together to do that?” There was also a call (supported by at least one a clinician), that a message be sent to RANZCP that it reject DSM-V. However, it was also pointed out that this might be taken to imply that participants at the workshop accept DSM-IV. In fact RANZCP does not endorse *any* particular diagnostic system, although it is likely that the college will debate the merits of DSM-V. The author of this report *is* considering putting before the Community Collaboration Committee of RANZCP the possible misuse of rating scales in supposed mental health assessment of pre-schoolers (part of the “B4School” health survey program). He is also about to submit a proposal for a 90-minute symposium on Psychiatric Diagnosis, a follow-up to our workshop, at the next congress of RANZCP in Sydney, in May 2013. Since this report will be distributed to people who were not present at the workshop, including overseas experts, debates deriving from the workshop may soon have an international outreach.

Practical suggestions for a follow-up meeting on diagnosis: “Repeating the experience would be the best practical way forwards” (from a psychiatrist) “Definitely support another hui⁴ and would attend. . .and before next year (from an administrator/manager). “Agree that sooner would be better – we can build on the momentum” (from the researcher/evaluator, non-academic). The suggestion was also aired that the topic of diagnosis be promoted for the next meeting of *Building Bridges*, which meets every third year, the next being in 2013. One who identified as a clinician/health worker suggested planning a conference around alternative approaches to diagnosis. In the meantime there was general support at the workshop to use a website/blog to keep the debate going, a view echoed in several of the feedback/evaluation forms.

Robert Miller
15.10.2012.

⁴ For non-New Zealanders, this is the Maori word for a meeting, a forum, or a conference.