Attending the 25th Quadrennial Congress of the International Council of Nurses (ICN) in Melbourne, Australia, this past May provided eye-opening perspectives on our specialty, psychiatric and mental health nursing. Worldwide, many things are the same in the field of mental health and illness, yet many things are very, very different. This editorial will describe, briefly, what ICN is, as a global entity, and then share what I learned about clinical and administrative similarities and differences around the world.

ICN is a federation of more than 130 national nurses’ associations, representing a wide range of countries, some very small and others very large. Over the years, the ICN has struggled with how to establish fair policies for voting when the delegates come together for their meetings every 4 years. Small countries, of course, think that one vote for each nation is fair. Large countries want a combination of one vote plus representation based on numbers of members belonging to their associations. At the Congress in Melbourne, this was one of the items discussed, with a new plan for voting emerging. The details will be published when the intricacies of the new arrangement are established.

The ICN was founded in 1899 by nurses from the United Kingdom (UK), United States, and Germany. Although it was headquartered in London for many years, its main offices today are in Geneva, Switzerland. It is now the voice for many millions of nurses, the only professional association recognized as having such a global perspective. When the delegates come together to debate issues and form governance directives, their local country practices and policies are brought to the table, but the final strategies are always addressed in ways that are meaningful worldwide.

According to Salvage et al. (2013), “The ICN works to ensure quality nursing care for all and sound health policies globally. Its many activities include leadership development; shaping nursing policy; fighting for nurses’ socioeconomic welfare; improving nursing practice, regulation, and education; and many [other projects]” (p. 1). Speakers in plenary sessions at the Congress, in their opening remarks, mentioned how ICN tackles major challenges, such as tuberculosis, HIV/
AIDS, mental illness, and primary health care. However, no plenary session had mental illness as the presentation focus. Also, in the program and poster sessions themselves, mental illness was not found as a subject as frequently as other topics.

**SIMILAR VIEWPOINTS OR APPROACHES TO CLINICAL CARE**

The theme, *Patients first*, was clearly voiced in many of the plenary and individual sessions. As the speakers described their new clinical approaches, the illness did not come first but rather the people who had encountered a trauma, infection, accident, or major environmental event (e.g., earthquake, tsunami). Nurses emphasized paying attention to how personal attitudes and knowledge (both their own and their patients) affected outcomes.

Perhaps because many of the delegates were from countries where poverty is common, and certainly the rich are in fewer numbers in those countries, the fact that physical needs must be addressed first stood out as an important theme. For instance, one of the speakers, whose topic was persuading adolescents not to engage in risk-taking behaviors, started with the admonition, “Feed them first!! No kid will listen to you if she or he is hungry.” Another, describing new approaches to community care, pointed out that homelessness needs to be a first concern.

A third, similar viewpoint was that the systems in which patients reside or where professionals work need to be centers front in problem solving. Systems thinking was apparent in presentations as diverse as helping patients who were lesbian, gay, bisexual, or transgender tell their families. Nurses have found that paying attention to work structures and environments—rather than individuals—results in identifying errors not as personal failures, but rather systemic, or organizational failures.

**WHAT’S DIFFERENT**

Most of the readers of the *Journal of Psychosocial Nursing and Mental Health* Services are probably more individualistic in their personal stances than family oriented. The majority of our readers are American, although our international readership is increasing. Americans, and others in developed countries, have been described as self-centered, ambitious, and more likely to consider work and other obligations before family. A “me-first” attitude is considered normal. Such was not the case as I listened to sessions, attended workshops, or engaged in informal conversations with nurses from developing countries, or where family values dominated over individual persuasions. *Family first* is the norm in many African and Euro-Asian nations and those with Latin/Spanish roots. Although it is true that individualism/familism are not polar opposites but rather a continuum, the differences noted at the Congress were remarkable.

Korea will be hosting the ICN convention in 2015 (before the quadrennial in 2017). During their educational presentations and also in the informal events designed to persuade the registrants to come to Korea, this family approach was very evident. Children entertained us with drumming and dancing. Family traditions were evident in the native food prepared for the receptions. God was thanked publicly and often.

Our Australian hosts included the native, tribal people within major parts of the program. Non-indigenous Australians hold individualistic values, similar to their UK and New Zealand “cousins,” but the indigenous Australians and New Zealanders are familialistic.

Another difference was the absence of pharmaceutical agents in the studies presented and in the exhibit areas. The reality is that psychoactive drugs are not available in poor countries and are in limited supply in many other countries.

The word psychiatry was not in common discourse at the ICN Congress. Rather, mental illness or mental health nursing was more common. Nurses in developing countries did not use “psychiatric nurse” as their title. In fact, the specialty, as such, does not exist in many countries. Patients with schizophrenia are not diagnosed, or are cared for in the primary care system.

**ANOTHER KIND OF “DIFFERENT”**

The World Health Organization (WHO), another global entity, does not have psychiatric or mental health nursing among its missions, and furthermore allocates a minute fraction of its resources to nursing, per se. A fact sheet prepared by ICN (2013) staff revealed “Data from the WHO human resources annual report of 2013 reveals nursing specialists represent 0.6% of staff in professional and higher categories. Medical specialists represent 90.7%.” (p. 1).

Should we, as psychiatric-mental health nurses, care? I think so. Being aware that “all is not well” in global health politics certainly should be a part of our awareness and knowledge. As individuals, we do not have the power or resources to fix the problem. However, we might be interested in becoming more active in the American Nurses Association, which is our local unit of ICN. And fixing the physician-dominance problem is certainly on ICN’s agenda.

**REFERENCES**
