Journal of Religion and Health (2019) 58:693–707
https://doi.org/10.1007/s10943-018-00748-9

ORIGINAL PAPER

My Personal Experience of Orthodox Psychiatry and Alternative Approaches

Ruth Smith[1]

Abstract

Ruth Smith's incisive and moving account of her experiences with orthodox psychiatry as delivered by the UK National Health Service sets the scene for this special section. She gives a detailed description of her own twelve years' experience as a Carer to her daughter, diagnosed with psychosis at age 24 years. She explains how they struggled to comply with the psychiatric services and cope with the, often traumatic, treatment provided to them. Clearly, we need to do better, but how? Smith explains how her study of critical texts and research papers on the subject helped to form her own critical viewpoint.

Keywords Critical psychiatry · NHS · Psychosis · Open Dialogue · Soteria · Alternatives

Personal Experience of Orthodox Psychiatry in the United Kingdom

The Crisis

On reflecting back to 2005, I would never have imagined that a system existing within the British National Health Service (NHS) could be so brutal and chaotic as the mental health services that I was to encounter in two English cities over the coming years. I have to admit that I was naïve, having faith in psychiatry much as I did in physical health care. My confidence was badly shaken by the events unfolding during February and March that year.

My daughter, Alice, had completed a degree the previous summer and was looking for work. She became increasingly depressed over the winter months and we sought help from her GP. We were told that there was a four-month waiting list for any psychiatric assessment or treatment and were advised to seek counselling in other community resources. Counselling was attempted with Alice but the

---

✉ Ruth Smith
ruth.counter-smith@hotmail.com

[1] 35 Channings, 215 Kingsway, Hove, East Sussex BN34FT, UK

depression deepened along with added anxiety and panic attacks. Finally, as her distressing thoughts and suicidal ideation increased, the GP referred her to the local Crisis Intervention Service. After several hours undergoing assessment by a duty psychiatrist and another team in the Accident and Emergency Department, it was decided that Alice did need treatment. However, it was recommended that she be treated at home by the Home Treatment Team rather than admitted into hospital.

Alice had become increasingly distressed and paranoid whilst undergoing the assessment and sedatives were given to her. Over the next few days, visits were made by members of the team and further medication (anti-depressant) was given to Alice, along with more sedatives. Team members visited but were never the same people. They usually stayed long enough to enquire how Alice was feeling and to check that she had taken her medication. I continued to trust this team and to believe that Alice would begin to improve “when the tablets kicked in”. However, Alice showed no sign of improvement in her mood. Her appetite diminished and she continued to express suicidal thoughts. She also described distressing bodily symptoms such as feeling that her skin was turning to plastic and that unusual smells were coming from her body.

Following this, the team considered that she should be given anti-psychotic medication as they thought she was showing symptoms of psychosis. I was somewhat worried about this as no explanation was given and I wondered whether it was a bit premature. However, the nurse who delivered the medication said that this would definitely help Alice, so again we trusted him. He left shortly after giving the medication and within half an hour, Alice became very distressed, as if in shock. It was difficult to know what was happening to her, but much later she explained that it felt as though she had been shot in the back of the head. Her whole thought processes disappeared regarding what she had been thinking and what was happening to her. That was her initial reaction. She then became very quiet and withdrawn, as if trying to understand what was going on. I found it very difficult to understand her reaction and was becoming extremely exhausted with the situation. Team members continued to visit and kept saying that the medications would help her once they all “kicked in”. But everything seemed to be getting worse. Alice became visibly more sedated and stupefied over the next few days. I became much more anxious and worried. One morning Alice left the house at 8 a.m. and, fortunately, I managed to persuade her to come back in. She told me much later that she had left in order to find a high building or bridge to throw herself off because she felt so unwell. At that point I had to lock the door and hide any means with which she might harm herself.

This situation continued over three and a half weeks, becoming ever more stressful as the days went by. My own anxiety increased as I was left to give Alice the medications which instinctively now I was beginning to suspect were not helping her. In fact, I wondered whether they could be making her worse. To her credit, Alice tried to contact the team and ask them to stop giving her the medication. At first they ignored her request but then said they would take her off them, but not for another few days as they needed a psychiatrist to supervise discontinuation. I think this was when Alice and I were both at our lowest point, somehow realising that this treatment was not going to help her but that she had to stay on it even longer than necessary! We were both exhausted and confused but I sensed that Alice was really feeling that she had had enough. I did not leave the house after that point.

A couple of days later, Alice told the team that she felt suicidal but did not admit to having any plans to end her life. Shortly after they left, Alice went upstairs and attempted to hang herself with a long woollen scarf tied to the stair banister. I cannot explain how I knew something was wrong, but I went looking for her upstairs and found her hanging in the stairwell like a rag doll. I went into overdrive and found sharp scissors to cut through the woollen scarf. I thought she was dead and, in fact, I found out later she would not have lasted a couple of minutes more. "A very close shave" was what the hospital consultant told us in the intensive care unit (ICU). I do not know how I got through that first night whilst Alice was in the ICU. I had been given two contradictory messages by duty doctors, one of whom left me with very little hope for Alice's recovery—even saying that "maybe it would be for the best if she didn't revive". I was in shock, convinced that she would not survive.

Fortunately, Alice did make it through the night and the next morning I was at the hospital with her. The Home Treatment Team did not visit or contact me. Later I raised a complaint about their service and this was upheld on every point, except for no admission of medical negligence. Later, I took this complaint further through legal channels because I wanted an explanation for myself and especially for Alice. I wanted to know why my daughter had almost died under their so-called home treatment plan. My trust in them had completely evaporated and I was feeling totally shocked, ignored, and angry. The legal case resulted in establishing that the Home Treatment Team were guilty on several counts. In particular, they had given Alice two medications that were likely to enhance her suicidal ideation, and therefore should have been closely supervised in hospital. The Trust settled out of Court with a relatively small sum of money, but I felt satisfied that we had found out the truth.

I believe that this initial horrific experience led to my growing distrust in the mental health system. At this point, I was traumatised and needing support myself. My feelings were complex, my thoughts confused and my passion for justice was aroused.

Life as a Patient/Service User

I have often wondered whether the mental health services turn vulnerable and distressed people into long-term patients by introducing them to a way of life dominated by the biomedical model. Most people in a crisis put their trust in the "experts" when seeking help and this is understandable. It probably stems from the long-held belief that doctors will not harm you. Therefore, when Alice was given medications without any explanation about the adverse side effects—only that she had to wait until they "kicked in"—this was acceptable to us both. What is not acceptable is that we were not told how these drugs would affect her in the short and long term and not given any choice about taking them. Even after her attempted suicide, further medications were given to her in hospital with no other treatment offered. One anti-psychotic (Olanzapine) began to affect her appetite immediately, increasing her usual weight from 140lbs to over 200lbs within 6 months. The fact that the drug had a major sedative component did not help either. Alice has sometimes gained even more weight since then, leading to worries about possible diabetes, heart problems and metabolic syndrome. Added to these physical health problems is the fact that people on these drugs frequently have a lifespan of up to 20 years less than normal (Joukamaa et al. 2006; Caplan 2011).

Being assigned a diagnosis within the National Health Service is a double-edged sword. Without it, a patient may not be able to claim benefits such as employment and support allowance (ESA) or disability living allowance (DLA, now personal independence payment (PIP)) and housing benefit. Yet a diagnosis can be problematic when people want to improve their quality of life. Alice had been actively seeking work prior to her crisis in 2005. After such traumatic events, hospital admission, and the adverse effects of the medication, she found life much more difficult. Her life seemed shattered and it took time and effort to pick up the pieces and find some sort of order again. Alice made valiant efforts, involving herself in voluntary work and various courses, keeping in touch with friends and relatives. However, the stigma of mental illness is very pervasive, both in society and within the mental health services themselves. Some of the professionals emphasised the “illness” as being a long-term disability which was not helpful. Ultimately, many people begin to self-stigmatise and lose hope in ever making a recovery. Any sign that they might be improving in their coping ability could be seen as their no longer needing any support or economic assistance. This can discourage people from gaining employment and perhaps improving their quality of life.

In addition, housing is a major problem for many people with mental distress and some resources can lead to further distressing issues arising. Alice was placed in a hostel with the promise that she would shortly be rehoused independently. This promise did not materialise and instead she met people from varying backgrounds (criminal and drug-related) who took her down the wrong path for a while. This led to more traumatic events and memories, with which she still finds it difficult to come to terms.

Despite asking for talking therapy when she was reasonably stable, Alice was never offered anything. Eventually, she managed to find a private therapist who she has been seeing now for about 6 years. She pays for this herself and has benefitted to a large extent through gaining insight into her distressing thoughts and beliefs. The fact that this relationship has been the only continuous professional one throughout those years has also been a major benefit. Alice continues to worry extensively over some of her past behaviour and the fact that she hasn’t achieved what she had hoped for. Her lack of self-worth and confidence cause her to become depressed very easily and she often feels life is not worth living and is easily triggered into panic attacks. Her energy levels fluctuate due to her continual problems with weight gain and exhaustion. The lack of good social engagement and a meaningful work life leaves Alice feeling very lonely most of the time. She sees her future as bleak and self-stigmatises, tending to see her past as problematic and full of mistakes made by herself and others.

Life as a Carer

In 2005, when the crisis occurred with my daughter, I was feeling extremely confused and overwhelmed with the whole situation. Obviously, I wanted to support Alice and willingly agreed to taking on the role of her Carer. I didn't realise at the time how the mental health services would both rely on me in that role and yet not support me. I was frequently not included in any treatment plans nor consulted over my daughter's care. Neither was it recognised that I too was suffering from a very traumatic experience—the fallout from the crisis had a very profound effect on me. I had no understanding of the unfolding situation and yet was expected to remain in control of myself. Although I was in a very distraught state of mind and was on long-term sick leave, I was providing much needed daily support for Alice, both in hospital and at home. My GP made an urgent referral to the Crisis Intervention Service for counselling and also prescribed sleeping pills to block out my continuous flashbacks. A couple of months later my employers also helped me to access therapy via the Tavistock Clinic in London which continued for 18 months. The mental health service offered me nothing until I filed my complaint against them three months after the crisis. Two very good friends stayed with me overnight on a rota basis and helped me through those first few months. In all, I took a year off work, returning part-time until I retired six months later.

My life had changed dramatically. I spent much of my time with Alice, helping her to adjust to life as a patient within the mental health services. For a few months, Alice moved into an independent flat with very low support. She felt lonely and isolated there and soon wanted to return home to me where she said she felt safer, knowing the neighbourhood much better. She began to make some progress and felt able to reduce and discontinue her anti-psychotic medication. Unfortunately, after a few months some of the symptoms of paranoia began to reappear and she was admitted into hospital for a couple of weeks whilst a new anti-psychotic drug was introduced. Looking back and with more knowledge about withdrawal symptoms, I think this was a mistake and the situation could have been overcome without the reintroduction of more medication. I have read much more about how anti-psychotics can lead to "supersensitivity psychosis", a recurrence of symptoms when withdrawing from the drug (e.g. Chouinard and Jones 1980). This was quite a setback for Alice and it led to another major problem, since other hospital patients who use illegal drugs can easily influence vulnerable people. This took place and it had a really bad effect on Alice and myself. Not only had my daughter started smoking again in the hospital wards after 5 years of abstinence, but now she was also introduced to a class A drug by another patient. My nerves were shredded by this time and I began to think that all was lost. What I had witnessed and come to understand was that mental health wards were unsafe places for vulnerable human beings. A further 6 months after hospital discharge were spent on helping Alice get over the psychological addiction to a dangerous illegal drug. It took a lot of hard work on both our parts.

I had been asking for family therapy since the first hospitalisation, when it was recommended by a hospital psychologist. Finally we were referred for therapy provided within the community mental health team. A psychologist worked with us both, sometimes together and sometimes separately over a 6-month period. Besides advising me about the developmental process of psychosis in a young person, he also validated my role as Carer being a very difficult one. He was able to give me advice about how to manage the task of being both a mother and a Carer. This intervention was helpful to me on a practical level and it also allowed me to consider my own needs as a priority. As a Carer, I realised my need to survive and I decided I would do this better by moving out of London. In fact, I was convinced we would both survive better in a healthier environment and we moved to a regional city in 2008.

In 2009, I joined a Carers group for people who understood the particular difficulties of enduring mental health problems. Besides the social contact, much information was shared regarding helpful resources and other useful networks. I was very fortunate at the time, as sadly this group was discontinued 2 years later, despite strong protests by group members. We were told that the local NHS Trust could no longer fund a facilitator for this monthly group. I also joined various Patient and Public Involvement groups in the Trust because this was a useful way to find out more about how the mental health services functioned and operated in the local area. Due to the constant restructuring of services, I didn't find out much that was helpful and soon started looking in other directions. I continued to feel excluded from the mental health services in my role as Carer. The issue of confidentiality raises many problems for professionals and makes it difficult for carers to work in partnership. I believe this is sometimes used as a smokescreen which allows the mental health services to exert exclusivity and power over patients/service users. I began to realise that I was a necessary economic asset to them, but was not regarded seriously as someone with a valid contribution to make regarding my daughter's mental health. The fact I was questioning aspects of the service probably did not place me in their favour.

I was keen to find alternatives to the biomedical model and I joined a group of people looking to set up a Soteria House (described later). I also began to attend conferences and read books about the anti-psychiatry movement. In this way, I gained knowledge and confidence over the next few years and became even more critical of mental health services. Meanwhile, my daughter was experiencing more psychotic episodes, sometimes resulting in hospitalisation and after-care treatment. I became increasingly concerned about the adverse effects of the medication on her, both mentally and physically. I was learning much more about the dangers of long-term dependency on these drugs. I couldn't understand why psychiatry continued to prescribe them whilst more research was showing how harmful the drugs can be. I began to realise that the majority of psychiatrists whom I encountered did not seem to be interested in anything except the dominant medical model. Fortunately, I have now found that some psychiatrists are critical of the model and do wish to see change.

About 3 years ago, I heard about the Open Dialogue treatment for psychosis—a very successful system used in Finland over the past 20 years with very little reliance on anti-psychotic medication (Gromer 2012; Stockmann 2015; Stockmann et al. 2017; Bergström et al. 2018). Substantial interest in this way of working began to grow over time and now training in Open Dialogue is taking place within a few

NHS Trusts in the UK. One of these Trusts in London has opened a service called Dialogue First and my daughter and I are currently receiving a service from them. Although I am still a Carer to my daughter, I do feel included in the Dialogue First service as it embraces family members and people in our network. It would have been very helpful to have had this kind of help 12 years ago. It is a very long process to overcome 12 years of toxic medications, several hospital admissions, and the traumatic experiences we have both suffered from a lack of good mental health provision.

Mental Health Services

I remember when I was working as a social worker in the 1980s how Community Care was hailed as the answer to the closure of all the large mental health asylums in the UK. It was felt that people would benefit from living back in the community and therefore become less institutionalised. A large amount of resources were promised, to be provided locally by way of supported housing, day hospitals and centres, with financial benefits available for anyone who needed help. Community Care teams were set up as part of the plan to support patients. The increased reliance on psychiatric medications enabled this to happen. Acute wards were increasingly placed in general hospitals to cope with crisis situations and short-term admissions. The UK Mental Health Act of 1983 ensured that a person was assessed as definitely needing hospital admission. Home Treatment Crisis Resolution Teams have been set up in most local areas whilst hospital beds have been reduced nationally. There has been much criticism of these teams, primarily because they are not adequately resourced and do not provide enough continuity in staffing to build relationships with vulnerable people. Also, they are very much focussed on the medical model—risk assessment and adherence to medication.

Despite successive governments stating repeatedly that there needs to be parity of care between physical and psychiatric services, the funding for mental health services is not ring-fenced and therefore can be siphoned off to other parts of the NHS at any time. So, the “Cinderella” of the services continues to be vastly underfunded. The lack of funding provided to mental health services over the years has, unfortunately, led to most of the original community resources being reduced or cut out completely (Neufeld et al. 2017; British Medical Association 2018; Cummins 2018). Much of the fallout from these drastic cuts has landed on families and friends. The emphasis is now placed on a family member or friend being named as the Carer. People with no family support frequently become isolated and depressed, returning in crisis to acute hospital wards on a regular basis.

In my experience, the focus of treatment plans for all mental health patients is primarily based on risk assessment and relapse prevention. Once a psychiatric diagnosis has been made, medication is often prescribed for ongoing treatment and this can lead to excessive amounts of varying medications over the long term. When a crisis arises there seems to be a total lack of ability to coordinate a proper response to people who need urgent help and support. Ultimately, people in crisis turn up at the Accident and Emergency Departments of general hospitals. Carers and family members are often not listened to or taken seriously by mental health staff, even though they often provide the main support for patients in the community. Although I am an articulate person, I have sometimes found it impossible to get any help and support from the services when my daughter is obviously in a crisis and needing help. We have been forced to sit in the general Accident and Emergency Department for 3 or 4 h, waiting to see mental health staff. On a couple of occasions, I have had to call the police because there was nobody else available. People in crisis may be taken to a police station and detained for varying amounts of time until they can be properly assessed. This can only add to a person's distress. Acute hospital wards are not a therapeutic resource and are not suitable for anyone who needs help getting through a psychotic crisis. In my experience, the staff do their best but are not sufficient in quantity or quality to take care of a ward full of disturbed and distressed patients. At the current time, due to lack of beds locally, patients can be sent to a hospital many miles away causing more distress to vulnerable people. This practice also means that it will be sometimes impossible for family and friends to make regular visits—something that can be the only therapeutic means of helping a patient to recover from their psychotic episode and bring some meaning back into their life.

Critique of Orthodox psychiatry

Moving to a Critical Approach

From the moment that I realised that the social workers and mental health professionals whom we were encountering were probably making mistakes I knew I had to raise my awareness. I was feeling very angry and confused because I felt my trust had been abused. When a social worker from the Home Treatment Team admitted that "we have let you down", many questions arose in my mind—how and why had they let us down? Alice was feeling very traumatised and more vulnerable after her near death experience. It seemed to have taken her to another level of confusion—"why did I do that?" she kept asking of herself and others, whilst becoming obsessive over a mark on her neck (left by the compression of the scarf).

After filing my complaint about the treatment we had received, I began to look more deeply into what had happened to Alice and myself. I began to read about the different medications and their adverse side effects. I listened to other service users' and carers' experiences of the mental health services. There were not many positive stories. I was searching for some sort of validation for my own feelings and eventually found it when I joined the local Soteria group. The book *Soteria: Through Madness to Deliverance* (Mosher et al. 2004), gave me an alternative view of treatment for people with psychosis—the idea of "being with" or "alongside" people whilst they are going through their crisis, often without medication. Since treatment at the Soteria House had proven successful (Calton et al. 2018; Lichtenberg 2011), I wondered why it hadn't continued to be utilised more widely. At a Soteria Conference in 2011, I also learned about the Open Dialogue method of treatment for psychosis used in Finland and, again, this raised more questions, since that too had often proven to be very successful over the last 20 years. And so it went on. At one conference I picked up the magazine "Asylum" and read about the Spiritual Crisis Network. I joined the network and learned a lot from their members and their founder, a psychologist—Isabel Clark. I gained a deeper understanding about spiritual issues connected with experiences of psychosis from reading her book chapter "Psychosis and Spirituality: The Discontinuity Model" (Clarke 2010).

Our local Soteria group later arranged a local conference where a medical journalist, Robert Whitaker, spoke about his research into psychiatry in America. His critical stance on orthodox psychiatry was extremely difficult to listen to as it took me to another level of anger and anxiety. I was really worried about the long-term effects of medication on my daughter—but the blinkers were off! I had to find out more. Whitaker (2010) states that:

> American psychiatry has told the public a false story over the past 30 years. The idea was promoted that drugs fix chemical imbalances in the brain when they do no such thing, and it grossly exaggerated the merits of the second-generation psychotropics. In order to keep that tale of scientific progress afloat (and to protect its own belief in that tale), it has needed to squelch talk about the harm that the drugs can cause. (p. 304)

Any critics of the story have been effectively silenced whilst the psychiatric drug business has excelled at expanding the market for its drugs, generating a great deal of wealth for many. Results that reveal the poor long-term outcomes with this paradigm of care have been hidden and the number of people disabled by mental illness during the past twenty-five years has soared with the epidemic now spreading to children. According to Whitaker: "millions of children and adolescents are being groomed to be lifelong users of these drugs"…..and "from a societal and moral point of view, that is a bottom-line that cries out for change" (Whitaker 2010: 328).

By this time, I had met a number of psychiatrists and mental health staff who totally subscribed to the biomedical model. It was very difficult to challenge them about medication, despite their views apparently being without any firm foundation. They would say things like, "Well, it is not an exact science", or "The benefits can outweigh the difficulties", or perhaps suggest an alternative medication. Although I recognise that medication can be useful for some people at times, it is also clear that there can be severe and harmful side effects. Many people are advised or coerced into taking these medications for life and, in any case, it is often extremely difficult to reduce or discontinue without medical supervision and support—which is not currently available. I was shocked to learn that there are no official guidelines available about withdrawal from anti-psychotics.

I am currently taking part in a research study headed up by Joanna Moncrieff, a British psychiatrist who is Reader in Critical and Social Psychiatry at University College London, and one of the founders of the Critical Psychiatry Network. This study (RADAR—Research into Anti-psychotic Discontinuation and Reduction)[1]

---

[1] See https://joannamoncrieff.com/2016/03/02/new-research-into-antipsychotic-discontinuation-and-reduction-the-radar-programme/ and https://clinicaltrials.gov/ct2/show/NCT03559426, both accessed 8 Nov 2018.

is now underway and will be looking at outcomes from a randomised control trial (RCT) study of patients with psychosis, where half the participants will be going through a process of gradually reducing or withdrawing from their medication. Moncrieff decided to undertake this research because of the need to assess whether patients would benefit from not taking anti-psychotic medication in the long term.

Moncrieff is critical of the idea that people with psychiatric problems have "chemical imbalances" and need drugs to be "normal". In her book, *A Straight Talking Introduction to Psychiatric* Drugs (Moncrieff 2009), she explains in plain language how these drugs work and whether they are effective, thus giving detailed information which allows people to make informed choices. In a more specific study into anti-psychotic medications, Moncrieff (2013) lays out her views about the use of these drugs. She challenges the accepted account that portrays anti-psychotics as specific treatments that target an underlying disease or chemical imbalance. Moncrieff dismantles the myths surrounding these drugs and shows that much of what we have been led to believe about their safety and effectiveness does not survive close examination.

In another recent guide to mental health diagnoses, A Straight Talking Introduction to Psychiatric Diagnosis (Johnstone 2014), clinical psychologist Lucy Johnstone (2014) carefully deconstructs psychiatric diagnosis and gives useful alternative explanations that now exist to help people in extreme distress. She uses personal narratives as evidence of people choosing not to take their diagnosis on as part of their identity. As one former service user states in her book:

> My recovery has been a long and painful road……..it needed me to reject the idea of being 'ill' and reclaim my sense of being human. It needed a sense of safety, trust and hope. It needed the people around me to be ready to face my narrative unflinchingly, no matter how painful, and to believe fully that I would find a way of making sense of it. Finally, it involved me subjecting the ideas I had been sold as a patient to scrutiny and making an informed choice whether or not to believe them. (Johnstone 2014: 114)

The British medical anthropologist and psychotherapist James Davies (2013), goes further in his book *Cracked: Why Psychiatry is Doing More Harm Than Good* (Davies 2013), a critique of psychiatric diagnosis which looks in detail at such catalogues of psychiatric illnesses as the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (currently in its fifth edition, American Psychiatric Association 2013). Davies asks why psychiatrists, without solid scientific justification, have kept expanding the number of mental disorders they claim to exist—from 106 so-called disorders in the first edition of the manual, in 1952, to 374 disorders in DSM-IV. Davies argues that numerous doctors have been enticed by huge rewards from pharmaceutical companies into creating more disorders and prescribing more pills, and that how mass-marketing has been unscrupulously employed to conceal from doctors, patients and the wider public the ethical, scientific and treatment flaws of a profession now in serious crisis. Davies points to the global expansion of psychiatric drugs. This expansion has been encouraged by the World Health Organisation despite WHO data suggesting that recovery rates in developed countries, where drug treatment dominates, are substantially lower than those in developing countries with lower levels of medication but more community support. He comments,

> Perhaps, ultimately, we are investing vast wealth in researching and treating mental illness because, unlike many other cultures, we have gradually lost our older belief in the healing powers of community and in systems that once gave meaning and context to our mental discontent. (Davies 2013: 258).

Alternative Approaches to Orthodox Psychiatry

The work of Moncrieff, Johnstone and Davies is part of a growing body of critical writing on the current state of psychiatric treatment in Western societies, and in particular on the continued dominance of psychoactive drugs as the primary mode of treatment. Whilst I accept that some people may be satisfied with the methods and drugs used by mental health services, many others feel trapped and damaged by the system. Given the dominance of the neoliberal political system, and the vested interest of psychiatry and the pharmaceutical industry in maintaining the biomedical model (e.g. Moynihan et al. 2002; Moynihan and Henry 2006), bringing about change in mental health practice is extremely difficult. Even though some service users may manage to get their voices heard, it is difficult to engage in protest or form a group identity amongst people who are an easy target for scapegoating and economic cutbacks. However, there are some strong critical voices emerging, and there is also a growing presence within Western societies of alternative models to that of orthodox psychiatry. In this section, I discuss some of these developments.

Amongst strong voices arguing for change is long-term mental health service user/survivor, Peter Beresford. Beresford has been a leading figure in the development of the movement for citizen participation and user involvement, particularly in relation to mental health and disability. He is currently professor of citizen participation at the University of Essex, and emeritus professor of social policy at Brunel University, and has written a series of influential books. In a recent article, he states:

> We need a convincing model to replace the dominant medical model. We know from research with survivors how damaging they feel that the medical model and its drug-dominated corollary is (Beresford 2016). It may not be helpful, but it has been effectively imposed on people socialised to feel inferior and deferential. It has worked; it has seemed to make sense and has carried conviction, and internalising it has often been the only gateway to support and resources.
>
> However, it is wrong for us as survivors to experience personal and social difficulties and then to be written off as abnormal, pathological and deviant. Key battles are now being fought over language and ownership, over knowledge, and over social and collective rather than individual and individualised understandings. (Beresford 2016: 352)

In 2014 and 2016, Beresford was the joint convener of the Mad Studies Stream at the Lancaster Disability Studies Conference. Mad Studies originated from the

Canadian Mad Pride movement; Beresford quotes Lucy Costa's description of it as "a co-operative venture, but one led by the experience, ideas and knowledges of 'mad-identified' people" (2016: 352). Beresford sees Mad Studies as potentially helpful, provided that, in his words, it "is led by survivors and their experiential knowledge; engages committed allies; and is de-medicalised and based on a social approach" (2016: 352).

In an article in the magazine *Asylum*, a journal of mental health sufferers and professionals founded in 1986 and taking inspiration from the anti-psychiatry movement of the 1960s, Tim Wilson (2017) questioned the usefulness of the "Mad Studies" label, but agreed on the need for a fundamental change in the dominant medical model. What is really required, he suggests, is to abolish psychiatry altogether, along with the associated implication that "madness" is an inherent property of the individual. Psychiatry should be replaced by "a new, public health approach to mental health" founded on an understanding of the social, economic, political and environmental causes of mental distress, and involving adequate resourcing for those who suffer from it. "It is abusive that the resources for mental distress are so severely rationed … Just think how much money we could save without a pill for every ill, think how many people could be saved from chronic disabling mental health conditions, how many children could be saved. We need to put money into alternative mental health schemes and up-stream preventative public health schemes" (p. 21).

I would add that provision of a proper Community Care approach is also needed, something which should have been done when the large asylums were closed down and sold off for private profitable developments. Other preventative strategies include providing innovative opportunities for social engagement, safe spaces, quiet spaces, peer groups, retreats, hearing voices groups, exercise groups, musical and art groups. Opportunities to take part in work-related activities, such as volunteering or skills enhancement training also need to be provided.

With regard to de-medicalisation, one helpful resource for some service users would be the formation of Medication Groups, giving honest information about psychiatric drugs, so that people could make informed choices about whether to take them or withdraw from them with appropriate support and medical supervision.

In crisis situations, there are already working therapeutic models which need to be expanded and funded to replace the current biomedical model. Crisis houses, a few of which exist in the UK already, such as Dial House in Leeds and Drayton Park in London, need to be expanded across the country. Soteria Houses need to be provided for people who need acute and longer-term care.

Open Dialogue is an immediate response to crisis and a way of organising non-medicalised ongoing care and support. Russell Razzaque, a consultant psychiatrist who works with the North East London NHS Foundation Trust (NELFT), and has led an Open Dialogue pilot scheme in England, explains how Finland was one of the first countries to pioneer such an approach:

> Treating acutely unwell patients involves regular 'network meetings' between the patient, her wider network of family, friends and the clinical team as well. The meetings are open, non-hierarchical and democratic, and the issue is approached, not from the perspective of 'professionals' here to help 'patients',

> but of people coming together to find mutual solutions for the problems at hand, using the resources available to them. This also means that they start out embracing the uncertainty of the moment and working out a pathway through a genuine process of listening without templates and pre-conceived notions. (Razzaque 2014: 199–200).

In the original project in western Finland, "Over 70% of patients with a first episode psychosis treated via the OD approach returned to study, work, or work seeking within 2 years, despite lower medication and hospital use compared to treatment as usual, with outcomes stable after 5 years" (Stockmann et al. 2017), a remarkably high success rate. A recent restudy of the initial cohort and control group indicated substantially better outcomes for the OD group over a period of nineteen years (Bergström et al. 2018).

Another recovery approach is Windhorse Community Services, an American home-based recovery project which was developed by Dr. Edward Podvoll and the Tibetan Buddhist lama Chogyam Trungpa:

> 'Windhorse' refers to a mythic horse, famous throughout central Asia, who rides in the sky and is the symbol of a person's energy and discipline to uplift him/herself. Windhorse is literally an energy in the body and mind which can be aroused in the service of healing an illness or overcoming depression. (Podvoll 1990: 224)

The approach is based on the Buddhist understanding of fundamental sanity and the inseparability of one's entire life from one's environment, whilst integrating applicable Western psychology.

In addition, talking therapies can be helpful individually or in groups. However, such resources need to be more easily available in the UK via the National Health Service.

Community resources such as The Hearing Voices Network, an international network of Hearing Voices Groups, provide safe spaces in the community where people can meet and share their unusual or extreme experiences of hearing voices, visualisations, paranoia and beliefs. Such groups offer people the opportunity to talk in confidence about their personal, often distressing life experiences. These groups can be very helpful for people who often feel isolated and stigmatised by the general population.[2]

Many more community initiatives which bring people together, such as Talk for Health[3]—a project in London which encourages and enhances communication between people, and The Reader—a project which began in Liverpool, bringing people together in groups to discuss literature in very meaningful ways,[4] can

---

[2] https://www.hearing-voices.org/.

[3] https://www.talkforhealth.co.uk/.

[4] https://www.thereader.org.uk/.

encourage connection and the building of relationships. The Dragon Café in South London is a wonderful resource, providing many creative activities for local people.[5]

Conclusion

In conclusion, I strongly believe that it is time to make radical changes to the current mental health services in the UK. How this will come about I do not know but I like to take a positive stance. Hopefully, more and more evidence about the harmful effects of the biomedical approach will become available and be more publicly transparent; then a more honest story can be told about current psychiatric treatments. Meanwhile, more service users, survivors, family members and friends will begin to make connections and form a stronger voice to demand changes in mental health services. Sympathetic psychiatrists and other professionals who are keen to help bring about changes will form alliances with groups in local communities who are seeking alternative resources. I particularly like the closing paragraph of an article by O'Hagan (2017), a service user survivor in New Zealand. With regard to the role of medical professionals, she uses the analogy of a household:

> If I own a house, I'm the project manager of the house and when things go wrong I call on different experts at different times to help me fix it up, if I feel I don't have the skills to do it myself. And that's how I'd like to see the mental health system: so that I'm at the centre, the project manager of my own services. The psychiatrists and the medical people need to get out of the hub and just be one of the spokes. (pp. 12–13)
>
> Well said, Mary—I like this vision.

Compliance with Ethical Standards

Conflict of interest The author declares that she has no conflict of interest.

Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed Consent For this type of study formal consent is not required.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5*. Arlington, VA: American Psychiatric Association.

Beresford, P. (2016). From psycho-politics to mad studies: Learning from the legacy of Peter Sedgwick. *Critical and Radical Social Work, 4,* 343–355.

Bergström, T., Seikkula, J., Alakare, B., Mäki, P., Köngäs-Saviaro, P., Taskila, J. J., et al. (2018). The family-oriented open dialogue approach in the treatment of first-episode psychosis: Nineteen-year outcomes. *Psychiatry Research, 270,* 168–175. https://doi.org/10.1016/j.psychres.2018.09.039.

---

[5] https://dragoncafe.co.uk/.

British Medical Association. (2018). Lost in transit? Funding mental health services in England. Briefing. Downloaded from https://www.bma.org.uk/collective-voice/policy-and-research/public-and-population-health/mental-health/funding-mental-health-services, 31 Oct. 2018.

Calton, T., Ferriter, M., Huband, N., & Spandler, H. (2018). A systematic review of the Soteria paradigm for the treatment of people diagnosed with schizophrenia. *Schizophrenia Bulletin, 34,* 181–192.

Caplan, P. J. (2011). Full disclosure needed about psychiatric drugs that shorten life. Psychology Today blog. Accessed at https://www.psychologytoday.com/au/blog/science-isnt-golden/201109/full-disclosure-needed-about-psychiatric-drugs-shorten-life, 30 Oct 2018.

Chouinard, G., & Jones, B. D. (1980). Neuroleptic-induced supersensitivity psychosis: Clinical and pharmacologic characteristics. *American Journal of Psychiatry, 137*(1), 16–21.

Clarke, I. (2010). Psychosis and spirituality: The discontinuity model. In I. Clarke (Ed.), *Psychosis and spirituality: Consolidating the new paradigm* (2nd ed., pp. 101–114). Chichester, UK: Wiley.

Cummins, I. (2018). The impact of austerity on mental health service provision: A UK perspective. *International Journal of Environmental Research and Public Health, 15,* 1145. https://doi.org/10.3390/ijerph15061145.

Davies, J. (2013). *Cracked: Why psychiatry is doing more harm than good*. London: Icon Books Ltd.

Gromer, J. (2012). Need-adapted and open-dialogue treatments: Empirically supported psychosocial interventions for Schizophrenia and other psychotic disorders. *Ethical Human Psychology and Psychiatry, 14*(3), 162–177.

Johnstone, L. (2014). *A straight talking introduction to psychiatric diagnosis*. Ganarew, UK: PCCS Books.

Joukamaa, M., Heliövaara, M., Knekt, P., & Aromaa, A. (2006). Schizophrenia, neuroleptic medication and mortality. *British Journal of Psychiatry, 188,* 122–127.

Lichtenberg, P. (2011). The residential care alternative for the acutely psychotic patient. *Psychiatric Quarterly*, *82*(4), 329–341.

Moncrieff, J. (2009). *A straight talking introduction to psychiatric drugs*. Ganarew, Monmouth: PCCS Books.

Moncrieff, J. (2013). *The bitterest pills: The troubling story of antipsychotic drugs*. Houndmills, Basingstoke: Palgrave Macmillan.

Mosher, L. R., Hendrix, V., & Fort, D. (2004). *Soteria: Through madness to deliverance*. Philadelphia, PA: Xlibris.

Moynihan, R., Heath, I., & Henry, D. (2002). Selling sickness: The pharmaceutical industry and disease mongering. *British Medical Journal, 324*(7342), 886–891.

Moynihan, R., & Henry, D. (2006). The fight against disease mongering: Generating knowledge for action. *PLoS Medicine, 3*(4), 425–428.

Neufeld, S. A. S., Jones, P. B., & Goodyer, I. M. (2017). Child and adolescent mental health services: Longitudinal data sheds light on current policy for psychological interventions in the community. *Journal of Public Mental Health, 16*(3), 96–99. https://doi.org/10.1108/JPMH-03-2017-0013.

O'Hagan, M. (2017). Madness in New Zealand: A conversation. *Asylum: The Magazine for Democratic Psychiatry, 24*(2), 12–13.

Podvoll, E. M. (1990). *Recovering sanity*. Boston, MA: Shambhala Publications Inc.

Razzaque, R. (2014). *Breaking down is waking up: The connection between psychological distress and spiritual awakening*. London: Watkins.

Stockmann, T. (2015) Open dialogue: A new approach to mental healthcare. Guest blog by British psychiatrist Dr Tom Stockmann. Accessed at https://www.psychologytoday.com/au/blog/hide-and-seek/201507/open-dialogue-new-approach-mental-healthcare, 31 Oct 2018.

Stockmann, T., Wood, L., Enache, G., Withers, F., Gavaghan, L., & Razzaque, R. (2017). Peer-supported open dialogue: A thematic analysis of trainee perspectives on the approach and training. *Journal of Mental Health*. https://doi.org/10.1080/09638237.2017.1340609.

Whitaker, R. (2010). *Anatomy of an epidemic: Magic bullets, psychiatric drugs, and the astonishing rise of mental illness in America*. New York: Crown Publishers.

Wilson, T. (2017). Mad studies? A response. *Asylum: The Magazine for Democratic Psychiatry, 24*(1), 20–21.