RECOGNISING AND SUPPORTING ALTERNATIVES TO WESTERN PSYCHIATRY[1]

We are strongly opposed to the assumption made by the Movement for Global Mental Health (MGMH) that the 'scaling up' of western biomedical psychiatric approaches is the only, or best, way forward for the promotion of mental health in LMICs. Mental health is as much a social and cultural phenomenon as a biological one. This insight is inadequately accommodated in western psychiatry, which relies too heavily on (i) intellectual frameworks and evidence rooted in mainstream western cultural systems of health and healing; (ii) research with western populations whose experience is not always easily generalizable to the experiences and suffering of people in other contexts; and (iii) evidence gathered and interpreted by mental health professionals, with inadequate attention to the experiences and voices of service users and survivors of psychiatry.

Many alternative approaches have developed in LMICs that may be more appropriate in those settings. Furthermore, and importantly, many alternative non-medical and user-led approaches have been developed in western settings by those who have not been helped by psychiatry. These too offer huge potential in LMIC settings where western psychiatry may have a poor fit. We list some of these below. Please note that this represents the early stages of a working document, and over-represents work in the UK and India from which many of our members are drawn. There are thousands of examples of locally appropriate mental health support we could have cited here from around the world. Much work remains to be done in expanding and refining the handful of case studies we mention here. However we believe that they provide a useful thumbnail overview of potential alternative (i.e. non-psychiatric) responses to the challenges of mental ill-health.

We do not seek to endorse any of the projects listed below, or to replace one form of hegemony (psychiatry) with another ('alternatives'). However we argue for a pressing need for global mental health actors to take greater account of these alternatives if they are serious about defining 'global' in a way that is respectful and inclusive of other (both non-psychiatric and/or non-western) ways of being, seeing and doing—rather than simply advocating the top down imposition of western biomedical realities on to non-western contexts, or indeed in western settings where many with poor mental health have felt that mainstream psychiatry has not helped them.

USER/ SURVIVOR LED APPROACHES:

Many argue for the greater inclusion of people experiencing mental ill-health in formulating approaches to health and healing, and methods of service evaluation, that resonate with their

[1] We seek to emphasise two categories of alternative approaches which are currently neglected given the dominance of western psychiatry: (i) non-western approaches (often developed in other cultures and contexts) and (ii) non-medical approaches - many of which have been developed in western settings by those who have not been helped by psychiatry.

own needs and experience—rather than the top-down imposition of biomedically driven frameworks.

Non-psychiatric approaches

In both western and non-western settings, these include for example organisations such as The Icarus Project[2] and The Hearing Voices Network[3], in which people experiencing mental distress seek to by-pass psychiatry as much as possible in formulating their own support networks and culturally and personally relevant responses to their experiences. Organisations such as the National Self-Harm Network[4] have played a key role in enabling self-harming people to understand the roots of their experiences in actionable and non-medical ways, locating their suffering in distress about traumatic experiences or in their resistance of often intolerable social pressures resulting from 'culture', 'tradition' and 'community'—reframing their experiences to see them as 'problems of living' rather than biological illness. Networks of survivor-led self-harm support groups exist in many western and non-western settings, such as India. However in the latter settings they are often clandestine in social environments that might be stigmatising or excluding—and we would argue that there is an urgent need to adapt and develop useful survivor-led practices from the West in LMI countries.

A growing number of internet and other resources make links to alternative approaches. One such resource is Asylum Magazine's 'Alternative Sources of Support' website[5], which lists multiple sources (both websites and organisations) providing "alternative support to people experiencing mental distress and madness". These focus on issues such as coming off psychiatric medication, coping with hearing voices and unusual beliefs, living with self-harm, coping with distress, helping people in crisis, art and creative writing, and alternative places

[2] http://www.theicarusproject.net/about-us - "The Icarus Project envisions a new culture and language that resonates with our actual experiences of 'mental illness' rather than trying to fit our lives into a conventional/ psychiatric framework. We are a network of people living with and/or affected by experiences that are commonly diagnosed and labelled as psychiatric conditions. We believe these experiences are mad gifts needing cultivation and care, rather than diseases or disorders. By joining together as individuals and as a community, the intertwined threads of madness, creativity, and collaboration can inspire hope and transformation in an oppressive and damaged world. We bring the Icarus vision to reality through an Icarus national staff collective and a grassroots network of autonomous local support groups and Campus Icarus groups across the US and beyond."

[3] http://www.hearing-voices.org/ - "If you hear voices HVN can help – we are committed to helping people who hear voices. Our reputation is growing as the limitations of a solely medical approach to voices become better known. Psychiatry refers to hearing voices as 'auditory hallucinations' but our research shows that there are many explanations for hearing voices. Many people begin to hear voices as a result of extreme stress or trauma."

[4] There is a growing variety of support for people who harm themselves. Particularly influential here is Louise Pembroke's work on harm reduction techniques and self-harm narratives. There are also various organisations for people who self-harm, e.g. http://www.nshn.co.uk/ - "We focus on support and distraction enabling people to seek alternatives to self harm. We aim to empower individuals to explore reasons for their self harm and to seek appropriate professional help. NSHN now equally support friends, families and carers of individuals who self harm."

[5] http://www.asylumonline.net/resources/alternative-sources-of-support/

of support. Another example is the book 'Alternatives Beyond Psychiatry',[6] which lists "current possibilities for self-help for individuals experiencing madness, and strategies toward implementing humane treatment", from 61 authors in five continents. The key question this book addresses is "what helps me if I go mad?"

User/survivor knowledge production

Much work is underway in several countries around the world to systematically influence the knowledge and practice around madness, mental health and service provision. Some seek to develop new ways to research, evaluate and reorient services so that they best meet the needs of users (e.g. Rose, 2014[7]), while others (e.g. Survivor Research[8]), in addition to this, focus on experiential research to question the hierarchy of evidence in what constitutes the knowledge base of mental health and ill-health. Such approaches are based on a strong critique of what currently counts as evidence in 'evidence-based medicine', based on research designs and frameworks which exclude user voices in the understanding, design, implementation and evaluation of services.

Users working in partnership with psychiatry

There are also important and promising international models of collaboration between users and western and non-western settings in working to make services more responsive to user needs. These include Heartsounds Uganda[9] (a service-user organization created after a visit from UK service-users to Uganda) and the Butabika-East London Link[10] (a hospital partnership between the UK and Uganda) and which are seeking to open up local-global collaborations in lobbying for more 'user/survivor friendly' services.

Other local responses include organisations such as Sharing Voices Bradford (SVB)[11], a community development project that offers alternative forms of help and support for people from diverse communities in Bradford, West Yorkshire. It promotes self-help and mutual

[6] Lehmaan, P and Stasny, P (2007) Alternatives Beyond Psychiatry. Peter Lehmann Publishing. The content list is available here: http://www.peter-lehmann-publishing.com/books/content/9780954542818.pdf

[7] http://www.birmingham.ac.uk/research/activity/social-policy/ceimh/film-resources/diana-rose.aspx Prof Diana Rose talks about her work in the field of users/survivor research in mental health, including user-produced knowledge, patient-centred systematic reviews, and constructing user-valued outcome measures. Also: Rose, Diana (2014) Patient and public involvement in health research: Ethical imperative and/or radical challenge? *J Health Psychology*, 19: 1, 149-158.

[8] http://www.survivor-research.com/ - "Survivor Research specialises in foregrounding the perspectives of mental health service users and survivors in the thinking and innovation around mental health, wellbeing and recovery. Our particular expertise lies in bridging the gap between user/survivor advocacy and research/policy. We are particularly interested in making the views and opinions of users and survivors from black and minority ethnic and other marginalised communities an integral and critical part of the overall service user/survivor voice."

[9] http://heartsounds.ning.com/ - "Heartsounds is an innovative initiative bringing together UK and Ugandan Mental Health champions to work together and learn from each others experience."

[10] http://www.butabikaeastlondon.com/

[11] http://www.sharingvoices.net

support, through community development. Members participate in activities of their own choice including fitness, music and faith groups as well as activities around art that are gender specific. Groups are a large part of helping members to develop collective action. Although the project works closely with psychiatric service providers and commissioners in the City, its work is grounded in a philosophy that is critical of biomedical explanations of and responses to distress and psychosis. An array of less medicalised approaches is developing all over the world. For example, the 'Dream-A-World Cultural Therapy' approach supports the mental health of vulnerable children in Jamaica, using creative arts to promote resilience and academic performance; increasing self-control; and promoting 'wholesome' identity[12].

CULTURALLY DRIVEN MODELS

Accepting a degree of suffering as normal

Acceptance (rather than treatment) of certain forms of (what bio-medical systems call) 'mental illness', particularly depression as an illness, is practiced in many cultures. These include a Theravada Buddhist inspired acceptance of depression in Sri Lanka[13], and an Ashanti acceptance in Ghana. This echoes our critique of the biomedicalisation of what are often normal 'problems in living'—such as grief, relationship breakdown, parent-child conflict and so on—often by drug companies eager to expand their markets[14].

Spiritual and religious approaches

Spiritism's basic principles have been drawn from different philosophical, cultural and religious traditions. In the Puerto Rican setting, therapeutic process is described by Espinosa and Koss-Chinoino (2014) as follows: "Spirit sessions continuously assess each of their participants spiritual needs. And, if a spirit is detected that insists on being intrusive, persistent and recurrent over the free will of another person, using the Spiritist diagnostic condition, "spirit obsession" mediums act to correct this situation"[15]. Various forms of ritual healing practised in India and Bali are also documented[16].

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[12] http://www.ttwud.org/mentalhealth/entry/dreamaworld-cultural-therapy-intervention-promoting-resilience-high-risk-primary#.U761VMtOWUk

[13] Obeyesekere, G. (1985) 'Depression, Buddhism , and the Work of Culture in Sri Lanka' in the A. Kleinman and B. Good *Culture and Depression. Studies in the Anthropology and Cross-Cultural Psychiatry of Affect and Disorder.* Berkeley, Los Angeles and London: University of California Press. http://books.google.co.uk/books?hl=en&lr=&id=qSXap1Us-CAC&oi=fnd&pg=PA134&dq=.+Obeyesekere,+G.+(1985)+%E2%80%98Depression,+Buddhism+,+and+the+Work+of+Culture+in+Sri+Lanka%E2%80%99+&ots=gcDcWpXg19&sig=XH3hJf7lpfdeumH8K5UNBWDRfno#v=onepage&q&f=false

[14] Moncrieff, J (2014) The medicalization of 'ups and downs': the marketing of the new bipolar disorder. Transcultural Psychiatry, 51: 581.

[15] Espinosa, J. S. and Koss-Chinoino, J. D. (2014) 'Puerto Rican Spiritism (*Espiritismo*). Social Context, Healing Process, and Mental Health', in P. Sutherland, R. Moodley and B. Chevannes *Caribbean Healing Traditions. Implications for Health and Mental Health.* New York and London: Routledge, pp. 136-127.

[16] Sax, William S. (2009) *God of Justice. Ritual healing and Social Justice in the Central Himalayas.* Oxford: Oxford University Press. Hobart, Angela (2003) *Healing Performances of Bali: Between Darkness and Light.* New York and Oxford: Berghahn Books

CREATING SOCIAL CONTEXTS THAT ENABLE AND SUPPORT MENTAL HEALTH

Mental distress is often as much the result of 'sick societies' as of 'sick individuals'. We seek to shift the focus of mental health work away from the de-contextualised individual and towards the individual-society interface, taking account of the interface between individual and the social setting in which s/he lives and/or works. A growing number of approaches focus on creating social and community contexts that enable and support the possibility of mental health.

SHORT-TERM RESIDENTIAL RETREATS FOR THOSE IN CRISIS

There are many models of non-medical residential settings to support those in crisis. Some follow the tradition of Soteria House originally set up in the USA in the 1970s (Mosher et al, 1995)[17]. Today there are Soteria Houses in the USA, Hungary, and Switzerland, working on the fundamental principles of helping people find subjective meaning in their experiences of "psychosis" and providing a safe space to recover. These include the Leeds Survivor Led Crisis Service[18] which offers an alternative to statutory mental health services for people who are in immediate mental crisis, providing a non-directive sanctuary where people are supported to recognise and develop their own strategies for crisis management. The service is run by people who themselves have experienced mental crisis. Recovery House[19], on an island off Scotland, offers free recovery breaks for individuals wishing to engage with their emotional, spiritual and mental health issues positively, and supports people to reflect on their recovery, including spiritual identity, building resilience, developing and cementing autonomy, extending friendship and peer support networks, engaging in meaningful activities and work. Maytree[20] in London, supports people in a suicidal crisis by offering a safe space and befriending. It offers a five-day free stay during which time individuals in crisis can rest, reflect, be heard and supported to consider their options and develop resilience.

COMMUNITY INTERVENTIONS

Social prescribing

Building on the link between community engagement and improved mental health, social prescribing[21] is an approach used by holistically oriented GPs in the UK as an alternative to medication and individual psychological therapies. It links people at risk of or experiencing poor mental health (low income single mothers, recently bereaved elderly, newly arrived individuals, people with mild to moderate depression and anxiety, people with long-term and

[17] Mosher L.R., Vallone R. & Menn A. (1995) The treatment of acute psychosis without neuroleptics: Six week psychopathology outcome data from the Soteria project. *Int J Soc Psychiatry*, 41, 157–73

[18] www.lslcs.org.uk

[19] http://www.workingtorecovery.co.uk/recovery-house-farm

[20] http://www.maytree.org.uk/index.php

[21] http://www.centreforwelfarereform.org/uploads/attachment/339/social-prescribing-for-mental-health.pdf

enduring mental health problems) to non-medical sources of support—through directing them to opportunities for arts and creativity, physical activity, learning new skills, volunteering, mutual aid, befriending and self-help and support with benefits, housing, debt, legal advice or parenting problems. Social prescribing may set up links for women or members of sexual or ethnic minorities who prefer support provided within their social groups.

Community interventions to tackle stigma and human rights abuses

Stigma is a key obstacle to caring and supportive responses to those in mental distress around the world, and local community mobilisation has to be part of stigma reduction efforts. Efforts to improve the treatment of those deemed "mentally ill" in resource poor settings, where people may lack the resources to support those experiencing mental distress in humane ways, need to be tackled through working with resource poor communities to develop locally feasible action plans to provide better care and support (rather than through abstract and top down legal rights frameworks). This point is discussed by Read in her study of shackling of the mentally ill in rural Ghana[22]; and another study of the rejection of psychotropic drugs by carers who would rather tolerate and manage psychotic symptoms of breadwinning family members than lose their contribution to survival-related manual work because of drug side-effects[23]. Such insights expand the brief of healing work to create community contexts that enable and support the possibility of mental health.

Community mental health programmes

Pune in India is home to several such programmes, three of which we mention here. The Seher Urban Community Mental Health Program[24] works in Pune slums to 'create emotionally sustainable communities', through training non-formal care givers who are trained in a wide variety of peer support, family counselling, arts based counselling and other healing techniques to engage communities on giving care to people with mental health problems / disabilities. The Ahamsetu Sustaining Lives in Cities Program[25] works to create supportive spaces within Pune city, based on enculturing life affirming food and body practices. Urban organic farming is a concept promoted by the project. Using arts based therapies, life skilling, and urban farming as livelihoods, the project offers healing opportunities for young people with first episode psychosis and other extreme states. Finally the World Center for Creative Learning Foundation[26] uses integrated arts (rhythm, colour, movement, sound, breath) to address the health and mental health needs of special

[22] Read, U, Adiibokah, E, Nyame, S (2014) Local suffering and the global discourse of mental health and human rights: An ethnographic study of responses to mental illness in rural Ghana. *Globalization and Health*, 5:13

[23] Read, Ursula (2012) "I want the one that will heal me completely so it won't come back again": The limits of antipsychotic medication in rural Ghana. *Transcultural Psychiatry*, 49 (3-4): 438-460.

[24] http://camhjournal.com/healing-services/comprehensive-urban-community-mental-health-interventions/

[25] ahamsetu@gmail.com

[26] http://wcclf.org/

populations, including people with mental health problems. The project has experience of over 15 years in addressing the healing and recovery needs of people with intellectual, mental and psychosocial disabilities.

Also in India, the Ishwar Sankalpa Urban Community Mental Health Program[27] addresses the needs of women in extreme states of health and mental health, living on the streets of Kolkatta, offering them needed mental health care services on the streets. The program mobilises communities, especially women, to offer befriending, peer support and safety nets for their clients without whisking them off into the state mental asylum. They also have a 'night shelter' arrangement for the women.

In Sri Lanka, Nest has six community health centres supported by its own Community Mental Health Workers (CHWs) trained in-house. Centres are run as communities that blend into the village in which they are located. They provide psychosocial support; information on wellbeing including mental health and HIV/Aids; awareness programmes; market gardening; library; first-aid (both physical and psychological) at times of crisis; and temporary accommodation when required. The CHWs that Nest trains provide support to state institutions including detention centres and rehabilitation centres for children, hospitals including mental hospitals, and to people abandoned by family and state institutions.

However, simply training local people to support those with poor mental health is not a 'magic bullet'. Members of marginalised groups who volunteer for such work may often place themselves at risk if they seek to intervene in complex social situations (e.g. women seeking to help children who are victims of rape by senior men in their village) without the backup of police and social services[28]. For this reason, community mobilisation projects are most likely to work when they are accompanied by efforts to ensure that community health workers receive appropriate support and backup by local police, primary health care services and so on. Much work remains to be done at this level.

LIVELIHOODS

Children of the AIDS epidemic in Africa have often been labelled as 'at risk' and in need of mental health services. However others have argued that such children are often poor rather than mad or bad, better served by interventions that support their resilience and strengthen potential community support networks than by the increased availability of psychological therapies or drug treatments. Against this background, organisations such as World Voices Positive in Kenya have worked to support child carers of dying parents—often under almost intolerable strain—through providing assistance with caring tasks and school fees, or

[27] isankalpa@gmail.com

[28] Petersen, I. (et al.) (2012). Understanding the benefits and challenges of community engagement in the development of community mental health services for common mental disorders: Lessons from a case study in a rural South African subdistrict site. *Transcultural Psychiatry*, 49, 418–437.

community cash transfer programmes to raise funds for impoverished communities to provide better support to children struggling to sustain AIDS-affected households[29].

POLITICAL LOBBYING

Much work remains to be done in collecting evidence of approaches that have sought to mobilise people with mental distress, their families and carers for better support, services and resources to enable their well-being. Thus for example, lobbying groups such as Jan Swasthya Abhiyan, the Indian wing of the Peoples' Health Movement[30] and Sahayog[31] continue to mobilise the poor to demand more culturally and socially appropriate responses to health, which take greater account of social determinants rather than the wholesale import of top-down biomedical approaches. Indian organisations have also pioneered important models of programmes mobilising the poorest of the poor in various ways to ensure greater accountability of primary health care services to the needs and experiences of people whose needs and worldviews are ignored by biomedically driven approaches. These approaches are often staffed by health professionals with little commitment to the worldviews or needs of their patients, particularly those of women and of people of lower social status. Much remains to be done in documenting this work.

Worldwide, organisations of users and survivors of psychiatry are engaged in political lobbying both in their own countries and internationally at the level of the United Nations. The World Network of Users and Survivors of Psychiatry[32], an international organisation advocating for the rights of users and survivors globally was instrumental in addressing issues of forced psychiatry and deprivation of liberty within the Convention for the Rights of Persons with Disabilities. The European Network of (ex)Users and Survivors of Psychiatry[33] is the grassroots umbrella organisation uniting people who are "on the receiving end of psychiatric services" and working towards human rights. The Pan African Network of People with Psychosocial Disabilities[34] was set up in 2005 to "promote and protect the rights and dignity of people with psychosocial disabilities on the African continent." These networks are doing much work to develop and share models of advocacy, support and services that originate in local realities and the specific needs of people and communities.

[29] http://www.wvpkenya.org.uk/ - see also Skovdal, M. (2012). Pathologising healthy children? A review of the literature exploring the mental health of HIV-affected children in sub-Saharan Africa. *Transcultural Psychiatry*, 49, 461–491.

[30] http://www.phmovement.org/india/

[31] http://www.sahayogindia.org/

[32] http://www.wnusp.net/

[33] http://www.enusp.org/index.php

[34] http://www.panusp.org/

CONCLUSION

Much work remains to be done on elaborating on the many thousands of socially, culturally and politically appropriate—often home-grown—alternatives to psychiatry. We are committed to developing responses to mental health that go beyond the 'cultural imperialism' implicit in current plans to expand the export of western psychiatry to very different settings. We hope the responses listed above give a flavour of the types of responses such an account might include.

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