

SOTERIA NETWORK

**an international movement
of service users, survivors,
activists, carers and
professionals
fighting for more humane,
non-coercive mental health
services**



SOTERIA NETWORK

Who are we?

We are a network of people in the UK promoting the development of drug-free and minimum medication therapeutic environments for people experiencing 'psychosis'. We are part of an international movement of service users, survivors, activists, carers and professionals fighting for more humane, non-coercive mental health services.

People who hear voices, have visions or experience reality in different ways to those around them — and become overwhelmed by their experiences — are often referred to as experiencing 'psychosis'. We believe that people can and do recover from difficulties which tend to be categorised under the term psychosis. This recovery can be with, without and sometimes despite psychiatric intervention.

Conventional psychiatry tends to regard 'psychosis' as part of a serious mental illness such as 'schizophrenia', 'bi-polar disorder' or 'psychotic depression'. We recognise that 'psychosis' can be extremely distressing to the person experiencing it and to those around them. However, we do not necessarily see psychosis as a bio-medical condition that requires set medical interventions. Rather, we see it as an acute personal crisis, marked by a range of extra-ordinary experiences, which may result from a number of factors, including trauma, psychological, neurophysiological, existential, spiritual, social and environmental. Fundamentally though, we believe that there is meaning in the experience.

Like many other organisations in Europe and America, we draw inspiration from the practices of Soteria House and the work of Loren Mosher and his colleagues. We continue to look for opportunities to develop and enrich this work, whilst holding to the broader principles of Soteria.

What is Soteria?

Soteria is a Greek word which means salvation or deliverance. For Loren Mosher, it was not the religious roots of the word 'Soteria' that were important, but rather the emphasis on safety and recovery.

Attempts to provide humane, therapeutic and non-medical support to people experiencing 'psychosis' has a long tradition. In the UK this tradition extends back to Moral Treatment and various forms of therapeutic communities such as the York Retreat, Kingsley Hall (associated with R.D. Laing and the Philadelphia Association) and Villa 21 (associated with David Cooper). This tradition is still active today, for example through the work of the International Society for the Psychological Treatments of the Schizophrenia and Other Psychoses (ISPS).¹

Indeed, alternatives to psychiatric care using small and supportive therapeutic environments are not new. In the Belgium town of Gheel, for example, as early as the 14th century, people in distress were cared for and treated in family homes (such an approach still continues at Gheel today). Countries, including Scotland, the Netherlands, Germany and others have adopted similar approaches and developed other humane non-medical ways of supporting people experiencing psychosis.²

Soteria House

Soteria House³ began life as an experimental research project in America. It was designed to see whether people experiencing a 'first episode' acute psychosis, who might otherwise be diagnosed with schizophrenia and treated with medication in hospital, might fare just as well in a house with minimum medication, but with maximum support.

The founder of Soteria House, the pioneering American psychiatrist Dr Loren Mosher, had been influenced by his early experiences as a hospital intern when he went through a period of personal helplessness whilst dealing with dying patients. This experience led him to question his medical training as well as his worth as a doctor. It helped him to realise

the importance of trying to understand the experience of his patients as well as the limitations of medical treatments for deeply human issues. Later in his career, when working as a psychiatrist, Loren Mosher was able to apply his knowledge and relate to the person experiencing 'psychosis' rather than the 'schizophrenic' that needed to be 'cured':

Because I hadn't found a large role for drugs in the helping process, I was led to believe more in interpersonal than neuroleptic 'cures'. I did worry about what went on in the 164 hours a week when my patients were not with me — was the rest of their world trying to understand and relate meaningfully to them? ⁴

What was Soteria House like?

The original Soteria House was as different in its philosophy to a psychiatric hospital as it was in its physical appearance. Based in a run-down, but not extraordinary, suburban area of California, it was, in a real sense, part of the community. A sense of 'homeliness' and community *within* the house itself was also essential, with the emphasis on establishing meaningful relationships. Inspired by Kingsley Hall and other therapeutic communities, Loren Mosher saw the value in staff and residents living and learning together, as far as possible, as equals. The staff at Soteria House tried not to impose too many rigid rules and structures, but did realise that more structure was needed than was found in some of the early therapeutic communities. It was important to make sure that the more distressed and disturbing residents felt safe and could be supported rather than just 'left to find their own way'.

Soteria employed a 'phenomenological' approach. This is a philosophy which attempts to see and accept things as they are, without passing judgement or interfering unnecessarily. In contrast to conventional psychiatry, a phenomenological approach draws attention to the importance of understanding the actual *experience* of psychosis from the point of view of the person experiencing it.

The core practice of interpersonal phenomenology focuses on the development of a non intrusive, non-controlling but actively

empathetic relationship with the psychotic person without having to do anything explicitly therapeutic or controlling. In shorthand, it can be characterised as ‘being with’. The aim is to develop, over time, a shared experience of the meaningfulness of the client’s individual social context — current and historical. (Mosher, 1999: 144)

The phenomenological approach helped Soteria staff to develop genuine empathy for their residents. The guiding principle was an emphasis on ‘being with’ rather than ‘doing to’. The challenge was to ‘be with’ a person to the fullest degree possible, and to guide them through their experience of extreme crisis in a non-coercive manner. Though the work was often demanding, it was also rewarding, a means of enabling someone to come through their crisis and gain an understanding of themselves and their place in the world.

The original Soteria house had no pre-set ideas about what ‘psychosis’ was, nor a predefined therapeutic model:

It is not the psychosis — whatever this might be — that is being treated, but a human being in the midst of an altered experience who is being supported and accompanied, realizing that each individual is very different from the other, and consequently there can be no ‘universal recipe’ ... no universal diagnosis ... or no ‘cookbook’. ⁵

Soteria residents, when able, took an active role in the daily running of the house. However, they were not given a set of ‘daily tasks’ or required to achieve certain goals by staff. The running of the house and sharing of work within it was enabled by regular community meetings. A support network developed that helped the residents to make the transition to life outside the house if they wished to access work, education, recreation, housing, etc. A crucial element of the support network was former residents; for they had a special understanding of the transition from Soteria to the wider community.

Who worked at Soteria?

Staff-to-resident ratio was high and most of the staff recruited to Soteria were non-professionals. It was felt that non-professionals would be best suited to a phenomenological approach, as they would be more free from

set ways of working and theoretical bias. In time, some former residents also took on staff roles within the house. Staff were carefully selected: they were open minded and did not hold dogmatic views regarding 'mental illness' or 'psychosis'. An ability to see beyond the confines of the medical view of 'schizophrenia' provided a sense of hope (as opposed to the usual bias towards poor prognosis) and a sharing of power between residents and staff. All staff were supervised by senior mental health workers, such as psychiatrists and psychotherapists, including Loren Mosher himself.

Was medication used at Soteria?

At Soteria psychotropic drugs were not routinely given. Residents did not generally receive psychotropic drugs during the first six weeks of their stay, and many took no neuroleptic drugs at all whilst at Soteria (neuroleptics being the current standard treatment both in and outside hospital). Those who did receive neuroleptic drugs were given doses far lower than those typically given, and they were given them for shorter periods. No or low-dose neuroleptic drug use was intended to avoid their 'dumbing down' effects which suppress emotional expression. Of course, it also lowered the risk of side effects, long-term toxicities and drug dependency. Minor tranquillizers (benzodiazepines) were sometimes used in the short term, for example to restore a resident's sleep/wake cycles.

Did residents actually benefit?

A systematic review of research studies on Soteria was recently published in the *Schizophrenia Bulletin* in 2008,⁶ which found that residents at Soteria did *at least* as well as patients who were treated with standard hospital treatment on measurements of 'symptoms' and 'outcomes'. Furthermore, there were additional benefits for Soteria residents. For example, because they were much less likely to be treated with neuroleptics, they were not subject to side effects, withdrawal effects and drug dependency. The authors concluded that the Soteria model offers an effective alternative treatment for people with a diagnosis of schizophrenia.

Unfortunately, despite these positive results, Soteria House did not survive for the long term. As is often the case, a lack of funding was crucial in its

eventual closure. As Soteria was originally set up as a research project, despite positive outcomes as well as enthusiasm for the project from both staff and residents, there was little political incentive to keep it going.

However, perhaps more fundamentally, Soteria's minimal use of psychotropic drugs was seen as a challenge to the prevailing medical model that came to dominate psychiatry. The shift towards short-term hospitalisation and drug treatments, and away from explicitly therapeutic environments like therapeutic communities, made projects such as Soteria unpopular with the psychiatric establishment. Reluctantly, Soteria House closed its doors in 1983, twelve years after it had first opened, though the support network for former residents built up around it continued for over ten more years.

Have there been other Soteria Houses?

Yes. Other Soteria projects have been successfully established in the USA, and also in Europe. The first house to follow from Soteria was Emanon which opened in 1974, also in California. The results from Soteria House had shown that its methods worked and having a replica house was seen as a natural progression. Born out of Soteria and Emanon came Crossing Place and later McAuliffe House, which were a development by Loren Mosher to incorporate the Soteria principles into existing community mental health services.

Crossing Place and McAuliffe House catered for people who are often described as 'revolving door' patients. Both Crossing Place and McAuliffe House were part of established community mental health systems. They were very influenced by Soteria and tried to keep many of its principles. However, they were different from Soteria House because they employed mental health professionals and the client group were long-term users of mental health services, who were experiencing various manifestations of emotional distress, including, but not exclusively, what might be seen as 'psychosis'. The outcomes from Crossing Place and McAuliffe House showed them to be cost effective and a good alternative to hospital.

Other houses based on Soteria, though not exact replications of the original, have followed, mainly in Europe where Loren Mosher's ideas have been

well received. Swiss psychiatrist Luc Ciompi founded Soteria Berne in 1984 and it continues to this day. Outcome results have again been positive⁷ and have inspired other Soteria projects in Germany, Sweden and Denmark. For example, the Berlin Runaway House is run on similar lines. In Hungary, the Soteria Foundation are working towards opening a Soteria House and have set up community projects based in Budapest which provide practical person-centred support for those affected by psychosis. A Soteria House in Alaska is anticipated to open this year (2008).⁸ For more information see the list of Soteria websites at the end of this booklet.

Although there has been a number of important residential and non-residential alternatives to hospitalisation in the UK, there has never been a Soteria House.

Do we still need places like Soteria?

Yes! We recognise that there have been substantial changes in mental health services since Soteria House. Social and economic drives have reduced hospital based provision in favour of short-term stays in acute wards in general hospitals, 'community' and/or 'home' treatment and 'early intervention'. We explain the limitations of modern mental health provision and why we still need places like Soteria today.

Neuroleptic medication

Neuroleptics (also known as antipsychotic medications) have become the mainstay treatment of people who are diagnosed with schizophrenia and they are also used to treat a variety of other 'serious mental health problems'. Whilst some people may benefit from these medications, many others do not. It is often stated that about a third of people diagnosed with 'schizophrenia' benefit, a third may 'recover' anyway, and a third do not benefit at all. In real terms, their use has not correlated with better outcomes. Studies undertaken by the World Health Organisation show that in countries where neuroleptics are not used to the same extent, equivalent or even better, outcomes are achieved. The questioning of their effectiveness alone places greater value on non-drug treatments, and when the risks associated with their use are also taken into account,

non-drug treatments become even more attractive.

Developments in pharmaceuticals have seen the introduction of newer 'atypical' neuroleptics with the promise of greater effectiveness and lessened 'side effects'. However, these promises have frequently fallen short of the reality and there is a lack of evidence for their larger claims. For example, comparisons between the older and newer neuroleptics have failed to really demonstrate convincing improvements in outcomes.⁹ Whilst some people do appear to benefit from these new medications, their efficacy is often overstated. Also, these new medications have not really addressed the 'side effects' that consumers find most troubling. People consistently complain about their unwanted effects, some are given these drugs against their will, and many feel pressurised into taking them or feel they have little other option. Recent evidence regarding the limited efficacy and associated risk of these drugs has led to calls for a more rational and honest justification of their use.

In addition, neuroleptics are often overused and used to manage other conditions where the evidence for their effectiveness is even weaker. In the past, those with learning difficulties were routinely given neuroleptics (whether experiencing 'psychosis' or not). More recently, we have seen people with a diagnosis of dementia being medicated with neuroleptics, despite evidence that their use is harmful to the individual. Critics have described the use of these drugs as a 'chemical cosh' employed to control and restrain those in residential care. In addition, some people who experience forms of 'neuro-diversity' such as autism and Asperger's syndrome can be diagnosed and treated as if they have 'schizophrenia' and find that anti-psychotics actually exacerbate their difficulties. Unfortunately, adverse reactions to these medications can often be seen as further evidence of an underlying 'mental illness'.

Soteria is not 'anti-medication', rather it offers people a choice; it doesn't see medication as the first, most important or only aspect of provision.

Community and Home Treatment Teams

Extreme distress or psychological disturbance can be very difficult to cope with, not only for the individual experiencing it, but also for people around them, especially families and friends. Whilst hospital admission is used as

a last resort, new approaches to 'community care' increasingly place great emphasis on 'home treatment' in the community. However, without access to adequate crisis services, attempts to support people in acute distress at home or in the 'community' can be a drain on a person's family and their support networks. Services are often scared of taking risks, under-resourced and only able to respond to acute distress if someone is seen to be a danger to themselves or others. In this context it is no wonder that community mental health teams often rely on medication. This is reinforced by a mental health system that is still dominated by a disease model of mental illness where medication is seen as crucial to reducing risk. This means that although social conditions may be 'taken into account', much of the work of community mental health teams is based around the management of a person with a psychiatric diagnosis through the use of medications. However, this does not fully take account of issues with withdrawal from medications and dependency arising from their use.

Services may have access to a local 'crisis house' although many areas still don't have these. Even so, these houses are usually only for short-term stays, which is often insufficient for a person trying to deal with their crisis without medication. In addition, many crisis houses do not accept people who are experiencing 'psychosis' (especially if they choose not to take medication).

Early Intervention in Psychosis

Another recent development is Early Intervention in Psychosis (EIP).¹⁰ Whilst a variety of support can be offered, individuals can be given early exposure to relatively small doses of atypical neuroleptics if they are considered to be 'at risk' of developing psychosis. There is no way of telling whether these people would go on to experience psychosis. However, it is increasingly being suggested that this 'preventative' treatment be given earlier and earlier. Ethical questions regarding such an approach have been raised in line with evidence that early use of neuroleptics is not always helpful, even for people that do develop psychosis.¹¹

There is growing evidence that neuroleptics do not always work, and that they can be damaging and difficult to withdraw from after extended

periods. Yet the so-called ‘critical period’ of treatment using neuroleptics by EIP teams is being lengthened, to as long as five years or more in some cases. Soteria’s approach avoids the ethical problem of early exposure to powerful psychotropic drugs. Soteria methods could be used to complement early intervention services, either by integrating Soteria principles into their practices or by offering an alternative form of support.

Community Treatment Orders

New changes to the Mental Health Act have introduced ‘Community Treatment Orders’ whereby people can be treated in the community without their consent, without having to be subject to a mental health hospital ‘section’.

Such measures have primarily been introduced as a response to media stories and a few high profile tragic cases. However, there is insufficient evidence that it really addresses the issue of public safety or the safety of the individual in question. Without adequate advocacy and legally binding ‘Advance Decisions’, community treatment, based on coercive methods, is seen by many service users as unhelpful and even oppressive.

NICE Guidelines

The National Institute for Health and Clinical Excellence produces guidelines for the treatment of various conditions, such as ‘schizophrenia’. Such guidelines have often been welcomed by many as producing a standard of care that should be adhered to. However, there is also concern that such guidelines actually reduce treatment options. The NICE guidelines for schizophrenia takes a primarily medical approach based on a supposed disease model and advocates a treatment regime where the necessity of medication is essential. Many people find this unhelpful and restrictive, and some have referred to them as the ‘not so NICE guidelines’!

The particular approach to ‘evidence-based practice’ fostered in the NHS results in services which offer treatments that appear to have the best results for the majority — the ‘best average’. However, this supposed ‘best average’ does not suit everyone. Drug treatments are more heavily

researched and lend themselves better to the controlled trials that are prioritised in health care research. However, just because particular treatments have outcomes that are easy to measure, it should not restrict access to other alternative services.

So how does Soteria fit today?

We believe that current services can, and do, often play an important role in mental health provision in the UK. However, they do not, and will not, suit everyone. We believe that in the modern era there is an essential need for Soteria-type provision in mental health services. This is because it addresses the following key issues:

Choice

The balance of power between patient and psychiatrist is heavily stacked against the patient. Choice in the treatment of psychosis is often reduced to little more than involving the patient in the decision as to *which* neuroleptic they will be prescribed. Service users in crisis find it difficult to avoid drugs being prescribed. Many worry that they will suffer coercion or a removal of support if they do not adhere to treatment regimes. Furthermore, support to help service users withdraw from psychotropic drugs is almost non-existent.

Choice is a fundamental part of healthcare and is being promoted in the NHS, and Soteria is something that should be offered as a choice. At the end of the day, Soteria, like any other intervention, should remain a positive choice, and not something which is forced onto people. The power relationship in the Soteria setting is more balanced and therefore potentially more therapeutic, especially if used alongside forward planning tools like Advance Decisions.

Advance Decisions

Advance Decisions are often called advance directives, advance statements, living wills or advanced planning tools.¹² They may include things like 'crisis cards' that people can carry around with them. They are basically documents that someone puts together that state in advance how they would like to be treated (or not treated) if, at some point in the

future, they lack the capacity to make their own decisions. They are very suitable for people who experience psychosis, who may have difficulty stating their wishes during an acute episode.

An Advance Decision can be drawn up to specify who you would like to be informed (or not informed) of your condition, what types of medication you would prefer to take (if any) and where you might like to be treated or supported (e.g. at home, in hospital or in a crisis house). Advance Decisions can be drawn up with the help of friends, workers and advocates. Unfortunately, they are not legally binding documents in the context of the Mental Health Act. However, they are supposed to be 'taken into consideration' when treatment and care are discussed, and may be influential in making decisions about people's care. It is possible, for example, that people could specify that they would like to be treated without medication, or with minimum medication in a Soteria-like environment, if one were available.

Recovery

The term 'recovery' is the new buzz word in services. Recovery is a very individual and personal issue and means different things to different people. Individually defined recovery is at the core of Soteria principles. Having said this we really need to ask ourselves what we mean by recovery. For many, recovery means getting back to a level of health or way of being that was experienced before the psychotic episode/crisis. But surely the seeds of the disturbance were present in the individual before the crisis, so should we really be aiming for a return to how things were? At Soteria there was an emphasis on the potential for growth and transformation in psychosis.

Psychiatric services may speak of recovery from psychosis, but the reality is that many people are *still* told that they will need to be on medication for the rest of their lives. Therapeutic pessimism is widespread and this is in stark contrast to the sense of hope and autonomy fostered at Soteria.

New ways of working with 'psychosis' and distress

Many people who have experienced psychiatric treatment first-hand have long demanded opportunities to receive non-coercive crisis support during

times of acute crisis and psychosis. Internationally people have developed a range of non-medical-based alternatives that work within people's own frameworks of understanding their experiences.¹³ In the UK, new creative individual and group-based strategies have been developed through organisations like the Hearing Voices Network, the Paranoia Network and individual professionals and survivors.¹⁴ In addition, there has been a lot of recent work to develop more sensitive ways of supporting people with various forms of neuro-diversity (or 'autistic'-related conditions)..

We hope to build on this work as we believe that Soteria principles can not only support people in acute crisis or distress, but can also support people to live with each others' difficulties and differences however defined. This could involve support with negotiating relationships, coping with unusual experiences and difficult circumstances, and even challenging what, at times, may be an unaccepting and hostile environment.

What could a Soteria approach offer?

Crisis provision — Soteria principles could be applied to already existing crisis provision. The value of 'being with' in such settings could elevate a crisis house beyond being a 'ward in the community' or just a place of short-term respite. Adequate funding and support is essential to effect this transformation.

Soteria Houses — Ideally we would like to see the setting up of Soteria houses in the UK, which would seek to replicate as well as develop the original model. These houses would need to incorporate new approaches to working with psychosis and other distressing experiences that have been pioneered by service users, survivors and their allies in recent years. As we have seen, the Soteria model has been applied successfully both to people experiencing psychosis for the first time, as well as long-term users of psychiatric services, and so we would like to see Soteria houses set up for both purposes.

Support in the community — In addition to Soteria houses we would like to see the development of other approaches that also draw on Soteria principles. One possibility is the development of networks of support that can be mobilised in times of need to support people in their own homes

or the homes of others. There are various ways this could be achieved. For example, there are instances where groups of service users/survivors/carers have supported each other in their own homes.¹⁵ These strategies have been found to be successful in terms of reducing admission to hospital, lessening unnecessary exposure to psychiatric drugs and supporting people to gain a greater understanding of their experience as part of a learning and recovery process.

Support for withdrawal — It is vital that people are offered support to withdraw from medication, should they wish to do so. This could range from supporting people in their own homes, to support in the community or crisis house provision. There is considerable evidence to show that withdrawal from psychiatric drugs requires support and that sudden withdrawal may cause severe emotional distress, perhaps due to withdrawal effects (which often mimic the symptoms of the 'illness') or because the original difficulties re-surface. Currently, if service users experience difficulties coming off medication, they are often put on higher doses of drugs and admitted to hospital rather than offered support in the community. Evidence suggests that those withdrawing from neuroleptic drugs appropriately, and with support, have better outcomes than those maintained on them.¹⁶ Soteria-type environments would be ideally suited to providing the necessary support.

New approaches to medication use — The minimal use of medication in Soteria projects is in line with alternative ways of understanding and prescribing medication proposed by a number of psychiatrists in the 'critical psychiatry' tradition, as well as other critical professionals and researchers.¹⁷ They argue that medications themselves actually *create* certain bio-chemical changes which can result in particular intended as well as unintended effects (the effects are remarkably similar regardless of whether people have a psychiatric diagnosis or not). So, rather than medications 'correcting' a 'chemical imbalance', they actually induce one. The resulting effect of the drug's action may, or may not, be helpful to the individual, depending on their particular needs and circumstances. For example, sedation from the use of minor tranquillizers may create a calming effect which might be beneficial if an individual is restless, agitated and unable to sleep. But this sedation is an effect of the tranquillizer's action on the brain, rather than its effect on

a disease i.e. it would have this effect both on people considered to have a 'mental illness' and those considered 'well'. The action of the medication is then quite different from that in general medicine where, for example, an antibiotic is used in the treatment of TB and breathing becomes easier due to the disease being treated.

By not viewing medications as agents that specifically target underlying *diseases* but instead looking at them in terms of their *effects*, one is led to question much of the common rationale for their use, such as arguments like 'medications for schizophrenia are just like insulin for diabetes'. This critical approach to the use of medication potentially provides a more open and equitable relationship between those receiving treatment and those providing it. This is because it promotes greater honesty about what medications actually do, and medication then becomes one of a number of options available to the individual in need.

Here and now for Soteria

The ideas of Soteria are formed from a basic human desire to support and live alongside people during acute personal crisis. The Soteria philosophy has inspired many people who want to develop a more compassionate and effective approach to people in distress/need. Consequently, Soteria is still alive and flourishing in different forms in different parts of the world. Opportunities exist to develop and expand Soteria principles to influence the direction of existing services and change the future of mental health provision. People experiencing acute distress or 'psychosis' deserve this opportunity.

Soteria Network in the UK

The Soteria Network was formed in 2004 in Bradford following a national speaking tour by the late Loren Mosher. The Network was inspired by Loren Mosher's work and adopted the name 'Soteria' to clearly indicate the values and principles the Network aspires to.

We are a loose coalition of like-minded people from different backgrounds and perspectives but who share the common ideal of promoting the Soteria tradition in the UK. We include service users/survivors, carers,

allies, critical mental health professionals and academics/researchers.

Our Principles

- We believe that people can come through severe distress with, without and sometimes despite psychiatric help.
- We try to support approaches that seek to enable people to make sense of, and come through distress in a non-coercive and non-oppressive way.
- We actively engage with the expertise found in individuals, families and culturally diverse communities.

Our Aims

- To raise awareness about the Soteria tradition in the UK.
- To support the development of non-medical alternatives to psychiatric services across the UK.
- To provide information and support to people who are genuinely trying to set up alternatives to the usual medical psychiatric response to experiences usually labelled as 'psychosis'.
- To network with other Soteria projects and organisations throughout the world and to draw on their experience to develop our work in the UK.
- To work with other groups locally and nationally who have an interest in developing non-drug alternatives.
- To work alongside service users/survivors and other critical mental health workers who are actively developing alternatives.

Our Activities

- We present and disseminate information about Soteria and similarly inspired projects through:
 - Soteria website and discussion forum
 - Newsletters
 - Published articles and information literature
 - Conferences
 - Local and national meetings
- We have hosted a number of Soteria Network conferences in association with the Centre for Community Mental Health at

Birmingham City University.

- We work alongside individuals, groups and organisations who share our ideals and try to support them to set up working alternatives and to learn from their experiences.
- We try to undertake relevant research to support and evaluate non-medical alternatives.
- We are in the process of developing a business plan that organisations can use to set up Soteria inspired projects in the UK.
- We offer support and consultancy to organisations who are interested in developing their projects along the principles of Soteria.
- We fundraise to support our activities.

How to get Involved



Soteria: Through madness to deliverance

**Loren R Mosher and Voyce Hendrix, with Deborah C Fort
2004, Xlibris, ISBN 978-1-413465-23-5 paperback, pp. 360**

**Available from www.amazon.co.uk, www.xlibris.com
and bookstores**

This book is the story, told by Loren R. Mosher, M.D., Voyce Hendrix, LCSW, and Deborah C. Fort, Ph.D., of a special time, space, and place where young people diagnosed as “schizophrenic” found a social environment where they were related to, listened to, and understood during their altered states of consciousness. Rarely, and only with consent, did these distressed and distressing persons take “tranquilizers.” They lived in a home in a California suburb with nonmedical caregivers whose goal was not to “do to” them but to “be with” them. The place was called “Soteria” (Greek for deliverance), and there, for not much money, most recovered. Although Soteria’s approach was swept away by conventional drug-oriented psychiatry, its humanistic orientation still has broad appeal to those who find the mental health mainstream limited in both theory and practice. This book recounts a noble experiment to alleviate oppression and suffering without destroying their victims.

SOTERIA NETWORK



LOREN MOSHER
1933–2004

Loren Mosher held many senior positions in psychiatry and mental health administration in the US.

He was the first Chief of National Institute of Mental Health's (NIMH) Center for Studies of Schizophrenia. While with the NIMH he founded and served as first Editor-in-Chief of the *Schizophrenia Bulletin*.

In 1970 he co-founded Soteria House and from 1970 to 1992 he was a collaborating investigator, then Research Director, of the 'Soteria Project — Community Alternatives for the Treatment of Schizophrenia'. In this role, he was instrumental in developing and researching an innovative, non-drug, non-hospital, home-like, residential treatment facility for acutely psychotic persons. The many publications from this experiment demonstrated both the feasibility and cost-effectiveness of its non-traditional approach to the treatment of persons newly identified as having schizophrenia.

In addition to over 100 articles and reviews, Loren Mosher edited books on the psychotherapy of schizophrenia and on milieu treatment, including *Community Mental Health: Principles and Practice*, written with his Italian colleague, Dr. Lorenzo Burti, in 1989. A revised, updated, abridged paperback version, *Community Mental Health: A Practical Guide*, appeared in 1994.

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