**FINAL DRAFT**

**UK NATIONWIDE APPEAL FOR A CLASS ACTION SUIT AGAINST A SELECTED PARTNERSHIP NHS TRUST EMPLOYING MEDICAL MODEL PSYCHIATRISTS**

**Purpose**

This paper seeks to encourage aggrieved and/or grieving relatives of people harmed by medical model psychiatry, to enlist the services of a sympathetic law firm, to mount a class action suit against a mental health partnership NHS trust, which continues to employ a psychiatrist whose prescribing practice, under the guise of “treatment”, has caused lasting harm and/or death.This model, which has been described as a pseudoscience (Wikipedia, 2020), has come under much criticism over many decades.

**Introduction**

Medical model psychiatry’s annual toll of premature deaths, in Europe and the USA alone, for the over-65s, has been estimated to be in excess of500,000 (Gøtzsche, 2015). When under 65s are added to this figure; and deaths in all countries and age groupsare included,worldwide, the total could *well exceedone million, annually.* This figure could be considered a conservative estimate, when sudden deaths due to cardiac arrythmias caused by psychotropic drugs (Withel, et al, 2003) are added, along with psychotropic drug useresulting in suicide (Walia, 2017;Takeuchi, et al, 2017). Also, the incidence of road traffic crashes and psychoactive drugs (Athanasia, et al, 2019); and psychotropic drugs and homicide (Hedland, 2018).

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It has been established, that the pharmaceutical industry’s products, overall, are the third leading cause of death after heart disease and cancer(Gøtzsche, 2013). The tragedy of medical model psychiatry-caused deaths, particularly, has now reached epidemic proportions and must be brought to an end.

Over my 45-year career, I have witnessed personally, within psychiatric hospitals and units, many deaths; and, have heard countless stories about how others have died – and at the time of writing – are dying nowdue to crass biomedical assessments and their practitioners’ belief in improving human happiness through chemistry (Van der Kolk, 2014), regardless of the debilitating effects.

**Premature deaths resulting from medical model practice**

Over the past 70 years or so, across the Western world, how many millions have died, prematurely, because of medical model psychiatry’s drug ‘treatments’? For those of us who work in the field of mental health, we know and observe daily how psychiatry works hand-in-glove with the pharmaceutical industry.

These premature deaths can take different forms. Firstly, there are those where prescribed psychotropic medication has resulted in chronic weight gain, lethargy and other effects, resulting in clients’ lack of exercise (or feeling unable to); and, as a consequence, their developing life-threatening physical illnesses, which then lead to premature death. Secondly, there is increasing evidence that some SSRIs (Selective Serotonin Reuptake Inhibitors) and some antipsychotics, particularly,are responsible for countless deaths (see references above).

Thirdly, the false messages put out,jointly, by medical model psychiatry and the pharmaceutical industry (Moncrieff, 2016), is so persuasive, many patients/clients believe that they have such a serious fault with their brain, that they need to take SSRI medication “to correct it”, for the rest of their lives. This has been described as “the chemical imbalance in the brain hoax”. (Gøtzsche, 2013; Moncrieff, 2016) This denies patients/clients the opportunity to receive effective talking treatments which can result in their living healthy, long, full and productive lives. There are many doctors today, in both primary and secondary care, who perpetuate this chemical imbalancehoax.

Steve Flatt, a colleague in central England (Flatt, 2020), suggests that a helpful way to look at our negative thoughts resulting in mental distress is to use the analogy of a bucket of water full of our thoughts. The bucket is full of water. When we are feeling good the water is sweet and clear. However, when we are feeling down it is like the bucket has been polluted with a bottle of ink, the water is cloudy,dark and unpleasant.

The big question is how do we clear the ink out of the water in the bucket? We can’t empty the fluids out of the bucket; we can’t drill a hole in the bottom and drain it (this our brain, remember!); we can’t bail it out. So how do we change the water?

The easiest and best way is to pour more clean water in to dilute the dirty water. The more clean water we pour in the less foul water remains in the bucket and eventually the water is good enough to drink again.

As you may realise the inky dirty water is our negative, threat-minded thinking and the clean water is forward looking hopeful thoughts that we desire.

We can no more scoop out our negative thoughts than we can scoop the ink out of the bucket of water. We must dilute our negative thinking with the thoughts we want and our hopes for the future. What will our bucket of water look like when the water is clean and pleasant? What will be in our lives, what will we be doing in our lives to help us to see and think the things we want in our lives? These are the ways we can cleanse the water - not by trying to challenge and remove each negative thought one by one as some therapies try to do. Antidepressants can be regarded as a form of bleach. It gets rid of the visible aspect of the ink but both toxins remain in the water until we purge it with sweet clean water.SSRI’s are the equivalent of bleach! Another toxin to hide the first.

There is another important point to make here,in this context. Increasingly, more enlightened mental health practitioners believe that the medical term “depression” results simply from either unexpressed negative emotion; and/or, undeclared or unresolved secrets from the past. (Griffin & Terrell, 2004) My observations over nearly half a century of working in the field with thousands of patients and clients,support this view.

**Unnoticed premature death**

Many thousands of the premature deaths go unnoticed, as patients are discharged ‘back to the community’ and quietly eke out their final years, out of public view. Others who are not admitted to psychiatric institutions are nevertheless prescribed medication and left on it without proper review for years in many cases, despite manufacturers’ recommendations around short term use. There is a very serious point at stake here: medical model psychiatrists and many GPs are playing the role of chemistry experts, harming rather than healing, in the process.

**First do no harm**

Part of the Hippocratic Oath states, “First do no harm”. Legitimate questions of concern could be asked, therefore, in relation to this. Firstly, is it not criminally negligent to go against the psychotropic drugs manufacturers’ stated recommendations of dose andtime period, when prescribing from the wide range of psychotropic medication? This could apply equally to antidepressants, anxiolytics and other antipsychotics.Might it be the case that simply continuing any prescription beyond the manufacturer's recommended date of maximum usethat puts a patient at risk (as outlined in the British National Formulary (BNF),is in itself,malpractice?Is it criminally negligent in cases where harm is caused?Are there any cases in law, of malpractice and/or harm from over-extending recommended limits with any other class of medication? If success could be achieved in simply criminalising non-conformity to existing manufacturer's limits, would this instantly reverberate throughout the entire health system?

It has been widely reported in countless studies, some being referencedabove, that psychotropic medication causes harm, so what are the reasons for increased prescribing across both the UK and other countries of the world?

It is now more common for GPs to prescribe a wider range of psychotropic medication, with little attention to reviewing or helping patients withdraw from it. Most of these clinicians, along with their medical model psychiatrist counterparts, are suffering from the AFAQL (Anything for a Quiet Life) syndrome. This is a condition whereby the clinician regards that it is better for the patient to continue taking the medication, regardless of its effects and consequences on length and quality of life, rather than risk the patient having “a relapse”. Community mental health nurses, who administer regular psychotropic medication to their patients, can suffer, also, from the AFAQL syndrome. Regarding the increasing use of psychiatric drugs, it is appropriate to quote Professor Sami Timimi, Consultant Child and Adolescent Psychiatrist: “We are in danger of creating morbidity on a massive scale with our current non-evidence-based mass use of psychiatric medication . . . The evidence is clear and the big question is not whether long-term prescriptions of psychiatric drugs does more harm than good, but what we are going to do about it.” (Timimi, 2020).From experience in both my own clinical practice and that of many colleagues, we have noted how effective talking treatments can avoid relapses; and, the need for medication in the first place. Increasingly, counsellors and other mental health workers are coming around to the hard fact that psychotropic medication is *not* treatment; it is mere symptom-masking. These drugs are no more a curative treatment than self-medicating with alcohol. A question worth asking here is as follows: clinicians, by continuing to write prescriptions beyond the manufacturers’ recommended date of maximum use: is this in itself malpractice?

At this point, it would be appropriate for me to state I am not opposed to all psychotropic prescribing. As a community mental health worker myself, in an earlier chapter of my career, I worked closely with both GPs and psychiatrists, recommending prescriptions for some patients, who were in danger of going out of control: hypomanic states, quick onset psychotic episodes and chronically low mood over many months duration, being particularly good examples. Short term use of a few days in the first case and a few weeks in the second and third, seemed to be efficacious in most instances.Talking treatments could then be more readily accepted by those who had been so disturbed.

**What is to be done?**

How can over a million people, every year, worldwide, with mental ill-health be spared this fate of premature death from the Pharmaceutical Industry -Biomedical Psychiatry coalition?

Firstly, it may be helpful to consider what strategies have been tried so far.

1. ***Local inquiries following a court case and prosecutions***. Often, there is a lot of chest beating at the time of such inquiries, with new policies being written and recommended changes being made. After the media coverage fades, existing staff move on or retire, all is then forgotten. Permanent changes to services cannot be guaranteed. A classic case of this was the Farleigh Hospital Inquiry in Bristol in 1971 (DHSS, 1971). Three ward staff were convicted of manslaughter, following the deaths of two patients in suspicious circumstances at this hospital.

Then, less than 40 years later, at Winterbourne View (DHSC, 2012), on the other side of the city, staff were again found guilty of abusing patients, with six care workers being given prison terms for “cruel, callous and degradingabuse” of disabled patients. Like Farleigh, these were learning difficulties patients, so it can be concluded that the recommendations from the Farleigh Hospital inquiry, thorough though it was, did nothing to protect Winterbourne View patients 40 years later. It was nursing and care staff who were the perpetrators at both Farleigh and Winterbourne View. Had it been medical model psychiatry’s practices which were under the microscope, it is likely that the same situation would have occurred all these years after the first inquiry. I have zero confidence in a public inquiry into psychotropic medication deaths, bringing about a lasting culture change.

1. ***The numbers of lawsuits*** against pharmaceutical companies, following the deaths of loved ones, and the sums paid out to litigants is unknown. In the USA alone, billions of dollars are paid out by pharmaceutical companies annually, most commonly by out-of-court settlements and accompanying non-disclosure agreements (Gøtzsche, 2013). Given the levels of multi-billion-dollar earnings from their products, these sums are easily affordable. Such lawsuits and pay outs do little or nothing to change future harms. It could be argued that these payments are made deliberately and cynically to prevent change.
2. ***Individual complaints against biomedical psychiatrists for negligence***.

Generally, complaints against individual psychiatrists for malpractice, go nowhere. However upset, annoyed or grieving a relative or harmed patient may be, their best efforts at redress will come to nothing.

The individual psychiatrists concerned wear a four-layer suit of tungsten armour, which is impregnable. The four layers comprise: their employing authority’s lawyers; the British Medical Association’s (BMA) legal defence team; the Royal College of Psychiatrists; and, the Medical Defence Unit and/or the Medical Protection Society’s lawyers (a network of medico-legal experts). Usually, it is only a question of time before the case is dropped. As an NHS manager, one of my expected roles (now to my shame) was to parry or delay such complaints, in the hope that complainants would not proceed to formalising their serious concerns of negligence or malpractice. Mostly, it worked.

1. ***Complaints about maltreatment to hospital authorities and/or health trustsand how the organisations respond.***

Over the decades, I have witnessed how hospital authorities deal with complaints about either aspects of the service or maltreatment by members of staff.

The initial response is usually courteous with the complainant being assured the matter will be investigated fully. Hospital managers may then not get back to the complainant with progress of the case, unless or until the complainant makes further contact.

If the complaint is minor, complainants may be reassured that action has been taken and all will see that such an issue will not recur. In cases where methods of treatment are challenged, more defensiveness is shown. In serious cases, the authorities brief their lawyers, who then advise accordingly. Much time can elapse and few cases proceed very far, if at all.

1. ***Setting up services of good practice to demonstrate that there is a better way.***

These have taken several forms:

1. Community mental health centres, where the team emphasises early-intervention, psychological treatments, in the form of individual and family therapy. High success rates can be achieved, with inpatient admissions cut, drastically. Sadly though, centres of excellence or best practice, generally, are short-lived. Thesehighly valued examples can be ended simply by a promotion or retirement of a key player; and/or the appointment of a young medical model psychiatrist or team leader, to replace his/her predecessor.
2. Crisis intervention services. These have taken the form of 24-hour or working day services, where GPs and out-of-hours social work services can refer to the crisis team. (Scott & Starr, 1981). Over the past 45 years, I have seen these come and go. They are regarded by medical model psychiatry as a threat, so various tactics can be used to bring them to an end. Most often, it seems this is achieved by starving of funding or of high-quality staff; or, a combination of both.
3. ‘Family Intervention – Open Dialogue Approach’(in the treatment of psychosis). The most noteworthy of this type of service was that of Jaakko Seikkula in Finland. After 5 years it was found that of the patients diagnosed as psychotic, 82% did not have any residual psychotic symptoms; 86% had returned to their studies or full-time employment; few were on medication; and, only 14% were receiving disability allowance (Seikkula, et al, 2004 & 2007).These results achieved, are highly significant. Serious questions could be asked of current mental health services as to why this clear example of best practice is not being rolled out across the UK – and indeed, the world.
4. Requests to local Departments of Mental Health for mental health professionals from other disciplines, to have significant input to psychiatrists’ training. There has been minimal success and/or inputfrom these overtures. Many requests are totally ignored.
5. Crisis houses. There were a number of these set up during the 1970s and 1980s for those experiencing acute mental health crises. Most were short-lived due to lack of funding and opposition from formal psychiatric services. The Soteria Network is a contemporary major provider of such a non-stigmatising service. (Soteria Network, 2020)
6. ***Publishing information demonstrating the myth of “a fault in your brain”.***

Exposing the fallacies in the ‘chemical imbalance in the brain hypothesis’ is important for both patients and therapists. It is in psychotropic drug manufacturers’ financial interests to continue to peddle this fallacy to prescribers. It continues, I believe, to be taught in medical schools. These prescribers then parrot it to their patients, to explain how antidepressants work. Much has been written on this topic; and, as usual, largely ignored by medical model practitioners and the pharmaceutical industry. Among the major contributions is the psychiatrist, Joanna Moncrieff, mentioned above, author of *A Straight-Talking Introduction to Psychiatric Drugs.* (Moncrieff, 2016).

1. ***Books, articles and conference presentations exposing the shortcomings and damage caused by medical model psychiatry***.

One tireless campaigner is Lucy Johnstone, whose seminal work in the 1980s*, Users and Abusers ofPsychiatry: a critical look at psychiatric practice* (Johnstone, 1989),described in detail what was going on in the psychiatric hospitals of theday, giving many examples of poor practice, in the form of vignettes ofactual cases. Medical model psychiatry reacted in its usual way: simplyignore both the book and its recommendations for change.

Then some 40 years later, Johnstone was speaking at a medical conference about the Power Threat Meaning Framework (PTMF) (Johnstone, et al, 2018a), as a constructive and helpful alternative to the medical modeland its shortcomings. She spoke also of the lack of anevidence base for medical model practice within psychiatry. The reaction when she had concluded:delegates hardly moved a muscle, showing no reaction(Johnstone, 2019). Did they hear theclear message communicated? Were they trying their best to ignore her thistime round, too?Silence is the best way to respond to yet another threat to'the 3Ps' (Power, Prestige & Pounds, sterling)?

**Review of the various strategies**

I have thoughtlong and hard about these various strategies to improve mental health services, over recent years, being aware how Teflon-coated medical model practitioners seem to be, in the face of complaints of malpractice. Over my long careerwith past roles of both mental health practitioner and mental health services manager, I have witnessed complainants being ground down over the years that a case drags on;for complainants to give up after just a short while. I have witnessed too, the ferociousness with which some clinicians’ lawyers threaten and intimidate witnesses such that accusations of malpractice have been withdrawn.

One particularly good (or bad!) example of a devout medical model psychiatry disciple was of a consultant psychiatrist, in one UKmental health service, within a 100 mile radius of London, who believed in both polypharmacy in his prescribing and chopping and changing drugs, at will. He would do this, via his mobile phone, either using texts or via live conversations with his patients, who were in distress (most likely because of his chaotic prescribing practice and advice). The number of times he found himself in the coroner’s court became an embarrassment to his employing partnership NHS trust. The outcome: with his agreement, a transfer to the post of consultant psychiatrist to the drug and alcohol service! (Their lives are less important?)

**Professional bodies that could takecorrective action**

Has the British Medical Association (BMA), a role to play in seeing that patient welfare is protected against the excesses of drug manufacturers and medical model prescribing? Under ‘Committees’, the BMA states:

“We represent the interests of doctors and patients across a number of branches of practice, professional activities and special interests, promoting excellent health care for all.” (BMA, 2020)

The BMA acts primarily as a trade union for doctors, however, they do speak up on key issues of concern to the profession. For example, they comment on drug withdrawal protocols and assisted dying propositions.

What of the Royal College of Psychiatrists (RCPsych)? Has this body a role in preventing medical model deaths? From the RCPsych website home page,a stated aim is as follows:

“We are the professional medical body responsible for supporting psychiatrists throughout their careers from training through to retirement, and in setting and raising standards of psychiatry in the United Kingdom.” (RCPsych, 2019)

Further:

“We work to secure the best outcomes for people with mental illness, learning difficulties and developmental disorders by promoting excellent mental health services, training outstanding psychiatrists, promoting quality and research, setting standards and being the voice of psychiatry.”

‘Best outcomes’; ‘promoting excellent mental health services’; and, ‘promoting quality’, would address this epidemic.

The RCPsych’s raising standards within psychiatry could cover psychotropic drugs’inappropriate, unnecessary or overprescribing?

Unfortunately, it seems that with both RCPsych and individual medical model psychiatrists, the main obstruction to change is the threat to their 3P’s. (We should never underestimate the primacy of this concern – even at the cost of countless premature deaths and damaged lives.)For commissioners of mental health services to regard other members of the multi-professional team as more effective in restoring mental health, at lower cost; and, without the need for medication is a real threat and (in the view of some) should be neutralised. Did this happen to the burgeoning mental health movement in the late 1970s/early ‘80s, championed by the CPNA (Community Psychiatric Nursing Association)?

**Class Action Suits**

Looking at other industries, I have been struck by the effectiveness of class action suits against employers and manufacturers charged with negligence. The asbestos tragedy of the 1960s is a case in point, where thousands of workers and family members developed asbestosis and/or mesothelioma, as a result of breathing in asbestos fibres (UK Pandi, 2004).

A more recent one has been the wrongly accused postmasters and postmistresses who, due to a computer mis-programming, led to prosecutions for fraud, resulting in prison sentences in some cases and loss of both income and career choice in others. (SkyNews, 2019)

Rather than a class action suit against a particularly egregious practitioner of the biomedical arts (who may resign, transfer out or die), perhaps a class action suit against the employing authority (which will not be going anywhere soon) would be a more effective strategy to bring about lasting change? In the UK this could well be a mental health partnership NHS trust.

In discussions with colleagues who feel similarly strongly about continuing poor medical model psychiatric practice, a worthwhile strategy might be to recruit 15-20 relatives of patients who have died, or who had their lives wrecked or harmed significantly, by prescriptions of psychotropic medication. A favourably disposed and well-versed law firm could present the case on behalf of this group of litigants, who would have to be prepared for the long-haul: maybe up to 7-10 years. Distraught and aggrieved relatives are a tenacious and resilient bunch: nb, the relatives of Liverpool football fans who died in the Hillsborough disaster. (*The Independent*, 2016) Their determination to get justice for their loved ones, propelled them through more than 25 years. The same could be true for those who have lost loved ones to biomedical psychiatric malpractice.

As a class action suit proceeds and with the accompanying media publicity, many partnership NHS trusts might seek to protect themselves from potential future litigation by asking their employed and yet-to-be appointed psychiatrists, “Do you obey the drug manufacturers’ recommendations about prescribing psychotropic medication?” Secondly, could directors and managers of partnership trusts be accused of negligence, in allowing unnecessary deaths to occur among mental ill-health patients under their care? If it were oncology patients being permitted to have damagingly high doses of chemotherapy and/or radiotherapy, with tragic consequences, would these same directors and managers, similarly, not be held to account? Might a charge of corporate manslaughter be levelled?

**Benefits arising from a successful outcome of a class action suit**:

1. It would make mental health partnership trusts wary about new psychiatrist appointments and the current prescribing practices of those employed. There would be closer questioning of applicants about their preferred ways of working with patients.
2. Psychiatrists could be taught psychotherapies in medical school as a replacement or modifying factor in maintenance therapy.
3. Psychiatrists, existing and newly qualified, would be encouraged to develop high quality listening and questioning skills, with minimal reliance on psychotropic medication. To do otherwise could have profound professional and personal risks; and, cost their employing authorities hundreds of thousands of pounds in damages through litigation.
4. The power, influence and profits of the manufacturers of psychotropic drugs would be curtailed significantly.
5. Savings on drug budgets, within mental health trusts, could be diverted to more useful services, of benefit to patients and clients.
6. More people with mental ill-health issues would have a better chance of surviving their episode of ill-health and go on to live fuller and more productive lives.

**Proving the link**

For a class action suit to be successful, it would be necessary to prove the direct link between the psychotropic medication prescribing practice and the patient’s/client’s death or deteriorated health. Clear statements from relatives to testify to the changed behaviour which occurred after the medication was prescribed, would give strength to the action. Under Freedom of Information (FOI) legislation, medical notes for deceased or harmed patients, could be obtained to support the case.

Under Common Law, a successful class action suit would set a precedent for similar actions throughout the country; and maybe, throughout the world.

**Other causes of needless deathsaddressed by the Law**

I remember only too well, the London smogs of the 1950s and the many deaths that resulted from chronic bronchitis and other life-threatening respiratory illnesses, caused by the poor air quality. I remember, too, the needless deaths on the nation’s roads due to drunken driving in the 1960s, which led to the new Road Safety Bill in 1966, where a limit was set of 80 mgs of alcohol in 100 cc of blood. Thereafter, it was a criminal offence to drive over this limit. Both in the UK and in countries across the world, central governments have taken decisive action to reduce deaths, significantly, from both these causes. Is it now high time that premature deaths from the combined actions of medical model psychiatry and the pharmaceutical industry be similarly reduced? Is it not even more important that this epidemic is tackled now, as many more lives are lost annually to this cause than the combined smog-related lung disease and road deaths due to drunken driving, in the 1950s and 1960s?

Psychotropic medication prescribing is an increasingly pervasive epidemic which needs to be controlled and is ripe for a class action suit.

It would be a fitting finale to my career within mental health services – where I have advocated unceasingly for patient and client welfare - if I witnessed a major prosecution of an employing authority, found guilty of employing medical model psychiatrists whose prescribing practices had resulted in numerous deaths or harmed lives. Such a prosecution would be a warning to other employers to adopt higher standards of scrutiny of job applicants at interview; and, to keep a close eye on current employees’ treatment practices. With other countries of the world adopting best practice, too, hundreds of thousands of lives would be saved annually and this epidemic of psychotropic medication-caused deaths would be at an end.

(Currently, there is a problem in the USA, where insurance companies will not reimburse doctors for providing non-drug treatments, so even willing doctors are forced into using prescription medications or doing nothing for the patient. Unbelievably, in these current enlightened times, their medical schools teach that depression and schizophrenia are lifelong illnesses; therefore, once you begin medication you are told that you must take it for life, unless you are no longer able to pay your health insurance premiums: then your medication vanishes when your money runs out. There are patients who have had to return to their home country because they could not pay for their health care in the USA. In many cases, the medication proved to be largely unnecessary.) Several large USA and Italian studies have shown that many patients will be largely recovered by middle age, anyway, and may no longer use medication of any kind.

**Media Publicity**

Even before a class action suit got underway, it would be of enormous benefit to recruit a skilled and experienced media advisor. Their role would be to ensure targeted publicity for the class action suit, via a range of mainstream and social media platforms, as the case unfolded.The publicity would need to be handled carefully, as still, there remains a prejudice towards mental illnessby the general public, who believe that mental ill-health affects others and has little to do with them.

**Financing the legal campaign**

Employing authorities and professional defence bodies, seemingly, have unlimited funds for defending legal cases brought. It would be necessary, therefore, for the organisation supporting the chosen group of aggrieved relatives to build up an enormous war chest in order to stay the course and pay for the best legal minds to win the case, however long that may take. We could be looking at £5 – 7million?

Well-wishers, philanthropists, sponsors, mental health campaigning groups and individuals and ambassadors for improved mental health services would be approached. Crowdfunding is an additional strong option for generating significant funding towards such a war chest.Whatever the amount of funding needed, the cause is both an honourable and ethical one. Campaigners would be acting in the memory of their loved ones whose lives were lost or harmed needlessly; and, to the hundreds of thousands of medical model deaths that have preceded them. More importantly, it would be saving lives and protecting peoplefrom a similar fate, worldwide,in the years and decades to come.

**Emotional and psychological support for litigants**

As mentioned above, aggrieved and bereaved relatives are a tenacious and resilient bunch. However, it will be important to support them to the maximum, both emotionally and psychologically during the legal process.Group cohesion would be increased and the dropout rate of litigants reduced, by these important and necessary supports. Lessons about this aspect could be learned from how the LiverpoolFootball Club relatives maintained their course and received moral and psychological support, following the Hillsborough disaster.

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27th June 2020

**References:**

Athanasia, H., et al (2019) Incidence of fatalities of road traffic accidents associated

with alcohol consumption and the use of psychoactive drugs.: a 7-year survey (2011-2017

BMA (2020)Role in protecting patient welfare.<https://www.bma.org.uk/about-us>

DHSS (1971) *Report of the Farleigh Hospital Committee of Inquiry*, Cmnd 4557

Flatt, S. (2020) Personal communication 24thJune, 2020

Google Scholar (Accessed 2020) <https://scholar.google.com/>

Gøtzsche, Peter (2013) *Deadly Medicines and organised crime: how Big Pharma*

*has corrupted healthcare.*p199Taylor & Francis.

Gøtzsche, P. (2015)*Deadly Psychiatry and Organised Denial*. People’sPress

Griffin, J & Terrell, I. (2004) *Human Givens: a new approach to emotional health and*

*clear thinking*. HG Publishing.

Hedland, J. (2108) Child and adult homicide in Sweden: epidemiological and forensic

features. Doctoral Thesis 5th June 2018

HSC (2012) *Winterbourne View Hospital: Department of Health Review and*

*response.* HSC. 10 December 2012

*Independent, The* (2016) Hillsborough victims' relatives to launch class action lawsuit

against South Yorkshire and West Midlands Police. (Accessed online 30th

March, 2020)

Johnstone, Lucy (1989) *Users and Abusers of psychiatry: a critical look at psychiatric*

*practice.* Routledge.

Johnstone, L. & Boyle, M. with Cromby, J., Dillon, J., Harper, D. et al. (2018a). The

Power Threat Meaning Framework: Towards the identification of patterns in

emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis. Leicester: British Psychological Society. Available from:[www.bps.org.uk/PTM-Main](http://www.bps.org.uk/PTM-Main)

Johnstone, L. (2019) Personal communication

Moncrieff, J. (2009) *A Straight Talking Introduction to Psychiatric Drugs.*PCCS

Books.

Moncrieff, J. (2016) *The Myth of the Chemical Cure: a critique of psychiatric drug*

*treatment.* N.Y. Springer

RCPsychImproving care.<https://www.rcpsych.ac.uk/> Accessed 16thAugust, 2019

Scott, Dennis & Starr, Irene (1981) A 24-hour family-orientated psychiatric and crisis

service. *Journal of Family Therapy* (1981) 3:177 – 186.

Seikkula, Jaakko & Mary E. Olson (2003) The open dialogue approach to acute

psychosis: its poetics and micropolitics.*Family Process* 42(3) 404-418

Seikkula. J., Aaltonen,J., Alakare, B., Haarakangas, K., Keränen, J. Lehtinen, K.

(2006) Five-year experience of first-episode nonaffective psychosis in open-dialogue approach: Treatment principles, follow-up outcomes, and two case studies. *Psychotherapy Research*Volume 16, 2006 - Issue 2

SkyNews (2019) Subpostmasters who sued Post Office 'vindicated' after High Court

ruling. <https://news.sky.com/story/subpostmasters-who-sued-post-office-vindicated-after-high-court-ruling-11888030> 16th December, 2019

Soteria Network (2020)<https://www.soterianetwork.org.uk/about/>

Takeuchi, T., et al (2017) The relationship between psychotropic drug use and

suicidal behaviour in Japan: Japanese Adverse Drug Event Report. *Pharmacopsychiatry*2017 50 (02) p69-73

Timimi, Sami. (2020) Personal communication.

UKpandi (2004) UK Asbestos: the definitive guide.

<https://www.ukpandi.com/fileadmin/uploads/uk-pi/legal/Lowe.pdf>(Accessed10th December, 2019)

Van ver Kolk, B. (2014) *The Body Keeps the Score: mind, brain and body in the*

*transformation of trauma.* Penguin Random House

Walia, V. (2017) Possible Role of Serotonin and Selective Serotonin Reuptake

Inhibitors in Suicidal Ideations and Attempts. *Journal of Pharmaceutical Sciences and Pharmacology***,** Volume 3, Number 1, March 2017, pp. 54-70(17) American Scientific Publishers

Watts, F. N. & Bennett, D. H. (1983) (Eds) *Theory & Practice of Psychiatric*

*Rehabilitation*. John Wiley & Sons.

Wikipedia (2020) Psychiatry is a pseudoscience.

<https://www.google.com/search?client=firefox-b-d&q=Medical+model+psychiatry%2C++a+pseudoscience> (Accessed6thApril, 2020)

Witchel, H.J, Hancox, J.C. & Nutt, D.J. (2003) Psychotropic drugs, cardiac arrythmia and sudden death. *Journal of Clinical Pharmacology* Vol 23 Issue 1 Feb 2003 p58-77

JhcCLASSACTIONSUIT MedicalModelPsychiatryFinalDraft 270620