MI-05 Psychosis and severe mental illness in a village: Soteria, Open Dialogue, Geel and moral treatment

HEALING after the FALL, research library, MI-05

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Scope and how to read this report

This report covers psychosis (schizophrenia, the other non-affective psychoses, mania and the psychosis that can follow childbirth) and its long-term care in a place with no psychiatric hospital and few or no drugs. It leaves alcohol withdrawal and delirium tremens to MI-06, and the ground of MI-12 and OR-08 to those reports. Phenobarbital and the stock rule are in CH-04, and the shelf life of salvaged medicines in ME-09.

Each section separates what the tradition says it does, what the record shows, and what modern science infers. The author's own inferences are marked [VERIFY].

A village of 300 can expect two or three people with a severe mental illness at any time. Schizophrenia has a median point prevalence of 4.6 per 1,000 and a lifetime morbid risk of 7.2 per 1,000 (Saha 2005). Bipolar I disorder has a 12-month prevalence of 0.4% and a lifetime prevalence of 0.6% (Merikangas 2011). That gives about 1.4 people with schizophrenia and about 1.2 with bipolar I in 300, and about 25 in a district of 3,000 [VERIFY: own arithmetic, ignoring the age structure, which lowers it]. Postpartum psychosis follows 0.89 to 2.6 of every 1,000 births or mothers in the studies reviewed (VanderKruik 2017).

1. The WHO outcome studies and the 'better outcome in developing countries'

What the studies said. The World Health Organization ran three linked studies. The International Pilot Study of Schizophrenia (IPSS) enrolled 1,202 patients in nine centres on four continents from 1967 and traced over 90% of them two years later. Patients in Agra and Ibadan had a markedly better course than those in the industrial centres (Sartorius, Jablensky and Shapiro 1977, read as a search summary only). The Determinants of Outcome of Severe Mental Disorders study (DOSMeD) then took first-contact cases in ten countries with active case-finding that included healers and shrines (Jablensky 1992). At two years, 37% of patients in developing-country centres were in complete remission against 15.5% in developed centres. Continuous unremitting illness was 11.1% against 17.4%, a difference that was not significant. Only 16% of the developing-country patients took antipsychotics continuously, against 61% in the developed centres, and 78.2% of the cohort were retained at two years (Jablensky and Sartorius 2008).

The International Study of Schizophrenia (ISoS) followed these cohorts for 15 and 25 years (Harrison 2001). Of 1,633 people, 1,005 (61.5%) were alive and assessed, 229 (14.0%) had died and 399 (24.4%) were lost. In the incidence cohort, 56.2% of all psychoses and 48.1% of schizophrenia had recovered on the Bleuler scale, with a range across centres from 26.8% to 75.6%. On a stricter definition 37.8% of people with schizophrenia had recovered, and only 16.3% if recovery had to be free of recent treatment. One in six (15.7%) recovered late, after years of illness. Over half

(52.9%) of the incidence cohort had taken neuroleptics for most of the previous two years, so the long-term recoveries were not, on the whole, drug-free. Hopper and Wanderling (2000) tested the developing-country advantage in 809 incidence cases against six possible biases, and it survived each one.

What the record shows on death. The same studies hold a darker figure. In ISoS the standardised mortality ratio (SMR) was raised in all but five centres. Groningen had 8.88, Hong Kong 5.76 and Mannheim 5.55. Of the 13 significant SMRs, four were in developing and nine in developed centres, and all five SMRs above 4.0 were in developed centres (Harrison 2001, Jablensky and Sartorius 2008). The WHO cohorts were in contact with services, unlike the village after the Fall.

The critics. Cohen, Patel, Thara and Gureje (2008) reviewed 23 longitudinal studies from 11 low- and middle-income countries and found that outcomes varied widely and were often poor. They argued that any measure of outcome must count excess mortality, suicide and human rights abuse, not only symptoms. (The brief names Minas as the fourth author. The paper read lists Gureje.) Burns (2009) argued that poverty, inequality, violence and social fragmentation cannot be good for outcome, and that the 'myth' rests on selected centres (read as a secondary summary only. The 'Burns 2011' paper on excess mortality named in the brief could not be found, and this report uses the population cohorts below for that question instead).

The rural cohorts show who died. In Butajira, Ethiopia, 38 of 307 people with schizophrenia (12.4%) died in five years, an SMR of 5.98 (95% CI 4.09 to 7.87). Infection caused 18 deaths (47.4%), malnutrition 5 (13.2%) and suicide 4 (10.5%). The mean age at death was 35. Those who took antipsychotics for less than half the follow-up had an adjusted hazard ratio of death of 2.66 (Teferra 2011). The authors concluded that their data challenge the belief in a benign course. A ten-year cohort of 919 people with severe mental illness in the same district recorded 121 deaths, 13.2% (Fekadu 2015, secondary summary only). In Bali, 15 of 59 first-episode patients (25.4%) were dead after 17 years at a mean age of 35.7, an SMR of 4.85, and only 23.7% were in combined remission (Kurihara 2011a). In a six-year community follow-up of 37 people in Bali, 19 of whom had never been treated, 27% were in complete remission (Kurihara 2011b). In Madras (now Chennai), Thara followed 90 first-episode patients for 20 years: 61 had full data, 16 had died and 13 were untraced. Only five had recovered completely and five had been continuously ill. Most had relapsed many times (Thara 2004). A 25-year report from the same cohort, read only in search summaries, gives 25 deaths, several by suicide, and a mean age at death of about 34 [VERIFY: the paper itself could not be read]. In rural Xinjin, China, 27.3% of 510 people with schizophrenia had gone untreated for over six months, and at 14 years this group had worse negative symptoms and more often lived alone (Ran 2018).

What modern science infers. The better symptom course in some developing-country centres is real and has survived bias checks. It does not mean that village life cures psychosis, and it says nothing about survival. Where people with psychosis live without care in rural poverty, they die about 20 to 30 years early, mostly of infection, hunger and suicide. Neither side argues that care is unnecessary. The central lesson for the book: the village may do well with the mind and badly with the body.

2. Geel: seven centuries of family foster care

The tradition on its own terms. Geel, in the Kempen of Flanders, grew around the shrine of Saint Dymphna. In the legend, recorded from the 13th century, Dymphna was a king's daughter who fled her father and was killed by him at Geel, and her shrine became a place where the mad came to be healed (Jay 2014) [VERIFY: details of the legend from a single secondary account]. Pilgrims made a novena of nine days at the church. A church was built in 1349 and a sickroom annex in 1480. Those who were not healed stayed, lodged with townspeople, and over centuries the lodging became the cure. The town's understanding was not medical: the boarders were guests, called boarders, and they worked on the farms and in the shops, sat at the family table and walked the streets freely (Jay 2014). Pinel praised the farmers of Geel as competent doctors of the mad, as reported by Jay.

What the record shows. The Belgian state took over from the Church in 1850 and opened a hospital in 1861 to

which boarders return when they cannot cope. The boarders numbered almost 4,000 in the late 1930s in a town of about 16,000. They fell to about 1,300 in the early 1970s, 550 in 2000 and a few hundred today, with estimates between 120 and 500 (Jay 2014, Hektoen 2024). The limit is now three boarders per family (Hektoen 2024). The state pays about €40 a day per boarder, of which the family keeps about half (Jay 2014). The decline comes from a shortage of families, not of boarders.

The romance must be checked against the chain. Under the Church, difficult boarders were sometimes chained and beaten. The 1850 state rules banned restraint and corporal punishment (Jay 2014). The return to hospital was, and is, felt by boarders as a punishment. Goldstein and Godemont (2003), the standard modern account, could not be read for this report, and no outcome, relapse, violence or mortality data for Geel's boarders were found in anything read. Roosens (1979) is the classic ethnography and was also not read.

The best outcome evidence for the Geel model comes from elsewhere. A Veterans Administration study in the United States first randomised patients to foster care or to staying in hospital, and foster care gave better social adjustment within four months. In the follow-up study, better outcomes went with more children in the home, fewer boarders and smaller homes. Too much stimulation, closer supervision by the sponsor and more intensive social-work visits were associated with worse outcomes for people with schizophrenia (Linn 1980, abstract only).

What modern science infers. Geel shows that family foster care can last for centuries in a farming town. It suggests that such care needs a place of retreat behind it and a reward that keeps families taking boarders [VERIFY: own inference]. It does not show what share of boarders recovered. The Linn findings fit the expressed-emotion research in Section 5: a quiet, ordinary household does better than an anxious, intrusive one. On the dispute between MI-01 and MI-02, Geel is consistent with both. Families were paid, which supports MI-02's view that a paid role holds care in being, and a state hospital stood behind the families, which fits MI-01's view that supervision is the active ingredient. Geel does not separate the two, and neither does anything else read for this report.

3. Moral treatment, the York Retreat and the asylum recovery figures

The tradition on its own terms. 'Moral' treatment meant treatment of the mind and the passions rather than the body. Its founders held that the mad keep a core of reason and self-control that kindness, regular work, good food, fresh air, religious meeting and the esteem of others can call back. William Tuke, a Quaker tea merchant, opened the Retreat near York in 1796. His grandson Samuel Tuke described its methods in 1813 (Tuke 1813, read only in catalogue entries). In Paris, Jean-Baptiste Pussin, the governor of the Bicêtre, removed the iron chains from patients there in 1797, and Philippe Pinel did the same at the Salpêtrière after 1800. The story of Pinel striking off the chains with his own hands is a later legend. Pinel credited Pussin, and straitjackets stayed in use (Wikipedia, Pussin) [VERIFY: dates differ between secondary sources].

What the record shows. Evers (2021) gives the fullest modern review. At the Retreat itself, about 10% of patients were in mechanical restraint at any one time, citing Digby's history of the Retreat, and in the 1830s it was criticised for failing to report its restraint. Both Pinel and the Tukes used straitjackets and leg irons, and the straitjacket was said to be a Quaker invention. John Conolly's 'non-restraint' at Hanwell meant padded seclusion rooms instead of straps. By 1858 all English county asylums had given up mechanical restraint, but in 1844 the American superintendents resolved in favour of it. Even Tuke wrote that moral treatment was futile in the first stages of acute insanity (Tuke, as quoted by Evers 2021).

The recovery figures were high and soft. Bethlem reported two thirds recovered in 1684 to 1703, and Exeter, Manchester and York reported about half cured between about 1775 and 1800. Pooled cure rates were about 40 to 45% before and during the moral era (Evers 2021). Samuel Woodward at Worcester State Hospital in Massachusetts claimed recovery in 82 to 91% of recent cases each year between 1833 and 1845. When Park followed up Woodward's 'recovered' patients of 1833 to 1846 in the 1880s, 58% had had no further episode (power2u.org, a secondary source only) [VERIFY]. Bockoven (1956) used the Worcester registers to argue that moral treatment achieved recovery rates that

the custodial asylum later lost. His figures could not be read for this report [VERIFY].

The critic of these numbers was a superintendent. Pliny Earle, in *The Curability of Insanity* (1876 paper, 1887 book), showed that asylums counted discharges, not people. One woman had been discharged 'recovered' 22 times in 20 years, seven times in one year (Earle 1887, read via the US National Library of Medicine biography). Thurnam's statistics of the York Retreat, reviewed in 1846, gave average recoveries of nearly 47% over 44 years, while at Midsummer 1840 only 15% of resident cases were regarded as curable, and Thurnam himself warned that dividing recoveries by discharges flatters the result (British and Foreign Medical Review 1846, read as a search snippet only). Asylums also chose curable cases. Bethlem refused patients ill for more than 6 to 12 months between 1853 and 1862, and a one-year discharge rule ran from 1837 (Evers 2021). At Butler Hospital about 35% were cured, 30% improved, 15% unimproved and 20% died, unchanged across 35 years, and by 1900 the asylum recovery rate was at most a third (Evers 2021).

What modern science infers. Moral treatment was humane and probably better than the madhouse it replaced. Its recovery rates of 40 to 50% are of the same order as the ISoS figures for first-episode psychosis, which suggests that much of what it 'cured' was the natural course of first episodes, mania and puerperal psychosis, all of which often remit [VERIFY: own inference]. Its numbers carry survivor bias, re-admission counting and case selection. Its founders were not abolitionists of restraint, and the book should not present them as such.

4. Soteria and Open Dialogue: little or no drug, intensive company

The tradition on its own terms. Loren Mosher opened the first Soteria house in San Jose, California, in 1971 with Voyce Hendrix. It was an ordinary house with six to eight residents, run by non-professional staff chosen for their ability to tolerate madness without fear. Staff were 'being with' the person through the episode, often for long hours at a stretch, and tried to understand the experience rather than suppress it. Antipsychotics were held back for the first six weeks unless the person was dangerous or did not improve, and stays averaged about three months [VERIFY: these details from secondary accounts]. Luc Ciompi founded Soteria Berne in 1984 on the same pattern with low doses of drugs (Ciompi and Hoffmann 2004).

Open Dialogue grew in the 1980s in Western Lapland, Finland, around Tornio. Its team meets the person and their family and network within a day of the first call [VERIFY], at home where possible, and goes on meeting them daily during the crisis. Every decision is made in the open meeting, with the person present, and the same team stays for as long as needed. Medication is discussed and often deferred (Seikkula 2006, Freeman 2019).

What the record shows. The Soteria project ran from 1971 to 1983. Bola and Mosher (2003) report 179 people with newly diagnosed schizophrenia-spectrum psychosis, 79 assigned consecutively from 1971 to 1976 and 100 assigned at random from 1976 to 1979. At two years, among 129 completers, Soteria residents did better on a composite outcome by 0.47 standard deviations ($p = 0.03$), and by 0.81 among those with schizophrenia ($p = 0.02$). The analysis of all 160 with endpoint data was weaker. Of the Soteria group, 58% took antipsychotics at some time during the two years and only 19% continuously. Mosher (1999) reported that 85 to 90% of people judged to need acute admission could be cared for without hospital, that Soteria matched drug treatment at six weeks, and that people with less than 30 days of previous hospital care did best. Calton (2008) reviewed three controlled trials with 223 participants and found equal outcomes, better in some domains, with much less medication. Soteria Berne reported equal or partly better results at much lower doses at comparable cost (Ciompi and Hoffmann 2004).

For Open Dialogue the record is observational. Seikkula's five-year cohort of first-episode non-affective psychosis is reported in secondary sources with 77 to 82% free of residual psychotic symptoms, 80 to 86% at work or study, and about a third having used antipsychotics (Seikkula 2006) [VERIFY: the abstract could not be obtained and the figures differ between secondary accounts]. A 19-year register study compared 108 Open Dialogue patients with 1,763 controls from the rest of Finland: Open Dialogue patients spent fewer days in hospital, drew fewer disability allowances and used fewer neuroleptics, and suicide did not differ (Bergström 2018). Freeman (2019) reviewed 23

studies of every design and found high risk of bias throughout and no randomised trial.

What modern science infers. Both models show that some people in a first episode recover with company, a quiet house and little or no drug, and both select first-episode patients. Neither shows that all can. Soteria's sample was small and its randomisation partial, and Open Dialogue has no trial. What a village can take from them is concrete: continuous human company in a low-stimulus place, a quick response, the family in the room, and drugs held in reserve rather than refused. What it cannot take is their staffing, which is several trained adults per resident, around the clock [VERIFY: own inference].

5. The family, the healer and the long-term place in the village

Family intervention. The strongest evidence in this field is for the least dramatic remedy. The Cochrane review of family intervention for schizophrenia pooled 53 randomised trials. Family work of at least several sessions, covering what the illness is, how to solve problems together and how to lower criticism and over-involvement at home, cut relapse by about half (risk ratio 0.55, 95% CI 0.5 to 0.6, 32 trials, 2,981 people, number needed to treat 7). It reduced admission (risk ratio 0.78, NNT 8) and improved adherence to medication (NNT 6). There were no data on suicide, and the trials were of poor methodological quality (Pharoah 2010). The mechanism has an observational base: across 27 studies, high 'expressed emotion' at home (criticism, hostility and emotional over-involvement) robustly predicted relapse, more so in chronic illness (Butzlaff and Hooley 1998). The WHO mhGAP guideline of 2023 gives family intervention and psychoeducation a strong recommendation on moderate-certainty evidence (WHO 2023).

Community care in poor countries. In India, the COPSI trial randomised 282 people with schizophrenia 2 to 1 to community care by lay health workers plus usual care, or usual care alone. At 12 months the difference in symptoms was small and not significant (PANSS -3.75, p = 0.08), disability improved modestly (IDEAS -0.95, p = 0.01), and the rural Tamil Nadu site did best (-9.29). There was one suicide in each arm (Chatterjee 2014). In Nigeria and Ghana, the COSIMPO cluster trial linked traditional and faith healers with primary health workers for 307 people with psychosis and found an adjusted PANSS difference of 15.01 points in favour of collaboration. Shackling fell from 57% to 9% with the intervention and from 42% to 10% without it, so the trial did not show that collaboration itself removed chains (Gureje 2020, via THRIVING library, TR-07). In a Ghanaian prayer camp, adding medication to prayer for 139 residents improved symptoms (effect size 0.48), but days in chains did not differ between arms (Ofori-Atta 2018, via THRIVING library, TR-07). Families accepted medicine before they gave up the chain.

The long-term place. People with psychosis did best with a role, suitable work, a household that did not criticise or hover, and a place of retreat in relapse (Linn 1980, Pharoah 2010, Jay 2014). In the village after the Fall, the person with schizophrenia is one of the 300, with a job, a bed, a watcher in relapse and a plan written down when well [VERIFY: own synthesis]. MI-02 adds that every lay mental health trial excluded or referred psychosis, so a lay counsellor cannot be assumed to manage it (THRIVING library, MI-02).

6. When antipsychotics stop

What the record shows. Both camps distort this question, so the figures are given side by side. Against stopping: in 65 trials with 6,493 patients, 27% of those kept on an antipsychotic relapsed within a year against 64% of those switched to placebo (risk ratio 0.40, NNT 3). Readmission was 10% against 26%, and aggressive acts 2% against 12%. Movement disorders were 16% against 9% and sedation 13% against 9% (Leucht 2012). In 1,210 patients, half of those stopped abruptly relapsed within 30 weeks, with little added risk afterwards to 3.7 years. A gradual stop delayed the time to 25% relapse from about 6 to about 10 weeks, and most of those who stayed well for six months stayed well long-term (Viguera 1997). Leucht (2012) did not find that abrupt or gradual withdrawal changed risk, which differs from Viguera, but both find most relapse comes in the first year.

For stopping, in some: in a Dutch trial of 131 people in remission after a first episode, a guided dose reduction or discontinuation strategy doubled relapse in the first 18 months (43% against 21%), and only about 20% came off

the drug completely (Wunderink 2007). At seven years, 103 of 128 were followed. Functional recovery was 40.4% in the reduction group against 17.6% in the maintenance group (odds ratio 3.49), and relapse rates had converged (Wunderink 2013). In Chicago, Harrow and Jobe (2007) followed 145 patients, 64 with schizophrenia, for 15 years. Those off antipsychotics had more periods of recovery ($p < 0.001$), and the authors attributed this to a subgroup with better prognosis. A widely repeated figure of 40% against 5% recovery comes from secondary sources and could not be checked [VERIFY].

What the guides say. The WHO mhGAP guideline advises at least 7 to 12 months of treatment after a first episode, a gradual stop and teaching the family the early warning signs (WHO 2023). MSF advises a taper over at least four weeks, and if signs of relapse appear, a return to the previous dose and then a slower reduction (MSF chronic psychoses). Neither guide gives a fixed taper for a person who has taken the drug for years.

What modern science infers. In the year after a stop, about half relapse, more after an abrupt stop and most within six months. A minority, perhaps a fifth to a third of first-episode patients, can stay well with low doses or none, and they may function better in the long term. There is no reliable way to say in advance who they are. After the Fall, the drug may simply run out, which makes a planned taper while stock remains far safer than an abrupt stop when it is gone (THRIVING library, CH-04 for the same logic with phenobarbital).

7. Telling psychosis from delirium, poisoning and infection

What the record shows. The commonest and most dangerous error is to call a delirium 'madness' and treat the mind while the body dies. MSF describes delirium (the acute confusional state) as rapid in onset over hours or days, fluctuating through the day, with disorientation, a clouded or drowsy mind, poor attention and memory, and hallucinations that are often visual. It is almost always caused by a physical illness: meningitis, severe malaria, encephalitis, septicaemia, syphilis, HIV, low or high blood sugar, salt imbalance, niacin or thiamine deficiency, thyroid disease, epilepsy, head injury, drugs (opioids, psychotropics, fluoroquinolones) and alcohol (MSF agitation and acute confusional state, the alcohol content left to MI-06). A primary psychosis, by contrast, usually builds over days to weeks in a person who is awake and oriented, knows where and who they are, and hears voices more than they see visions [VERIFY: the contrast is the standard clinical teaching and was taken from MSF's description of delirium, not from a separate source on psychosis].

The look-alikes the brief names, and what the library holds on each:

- **Cerebral malaria.** Fever, then confusion, fits or coma in an endemic area. Psychosis can also follow treatment: 51 cases of psychosis after chloroquine were recorded in a malaria-hyperendemic Indian district (Biswas 2014), and a post-malaria neurological syndrome can present as new psychosis weeks after cure (Agarwal 2022, case report). Quinine, chloroquine and mefloquine also add to the heart-rhythm risk of haloperidol (MSF haloperidol).
- **Typhoid.** Fever for a week or more with a 'typhoid state' of delirium, stupor or coma. Dexamethasone cut deaths in severe typhoid with these signs from 10 of 18 to 2 of 20 (Hoffman 1984, via THRIVING library, IN-11).
- **Pellagra.** Dermatitis on sun-exposed skin, diarrhoea and dementia or psychosis in a maize-dependent diet, ending in death. Treatment is nicotinamide 100 mg three times a day (MSF, via THRIVING library, HY-08).
- **Datura poisoning.** *Datura stramonium* and related species (thorn apple, jimsonweed: seeds, leaves and flowers) cause the anticholinergic toxidrome: hot dry flushed skin, wide pupils, fast pulse, urinary retention and a delirium with picking at the air and visual hallucinations. One seed holds about 0.1 mg of atropine, onset is 30 to 60 minutes and the delirium lasts 24 to 48 hours. Among 47 poisoned children in India, 31.9% needed intensive care (THRIVING library, CH-03).
- **Thyroid disease, head injury, epilepsy and drugs.** After a fit, a person may be confused or psychotic for hours to days (THRIVING library, CH-04). After a head injury, agitation calls first for a check of the bladder

and a mattress on the floor, and haloperidol only in small doses, 1 mg in an adult and 0.5 mg in a child (Primary Surgery, via THRIVING library, WO-07).

- **Alcohol.** Intoxication, withdrawal and delirium tremens look like psychosis and kill. They belong to MI-06, and this report does not treat them.
- **Mania.** Overactivity, little sleep, rapid speech, grand ideas and spending or giving away goods, often with a past episode of depression. It can be psychotic. MSF treats it with haloperidol 5 mg once a day up to 10 mg, a maximum of 15 mg, for 8 weeks after remission (MSF haloperidol).
- **Postpartum psychosis.** Onset usually within days to weeks of birth. First exclude puerperal sepsis and eclampsia (THRIVING library, MA-04). MSF advises the lowest dose of haloperidol in a breastfeeding mother (MSF chronic psychoses).

What modern science infers. In a village with no laboratory, the rule is that new confusion with fever, drowsiness, fits, recent childbirth, a new drug, a poison or a head injury is a body illness until shown otherwise. The microscope at the dispensary rung (thick film for malaria) and a thermometer change this more than any drug [VERIFY: own inference].

8. Salvaged antipsychotics: history, benefit, harm and dose

History. Chlorpromazine was synthesised at Rhône-Poulenc in December 1950. Henri Laborit used it in anaesthesia, and Jean Delay and Pierre Deniker at the Sainte-Anne hospital in Paris introduced it into psychiatry in 1952. It reached North America in 1954 (López-Muñoz 2005). Haloperidol followed in 1958 [VERIFY: date not taken from a source read]. These two remain the cheap first-generation drugs most likely to be found in a salvaged stock. FO-11 lists haloperidol and biperiden on the village and district shelf (THRIVING library, FO-11). ME-09 holds no data on antipsychotics specifically. Its general finding is that dry tablets stored below about 25°C mostly keep their potency years past the printed date, in the US Shelf Life Extension Program 88% of 3,005 lots were extended, by a mean of 66 months (THRIVING library, ME-09). Applying this to haloperidol and chlorpromazine tablets is an extrapolation [VERIFY]. Chlorpromazine tablets are light-sensitive, and both MSF monographs say store below 25°C (MSF haloperidol, MSF chlorpromazine).

Benefit. Antipsychotics cut relapse by about 60% (NNT 3) and aggressive acts by about four fifths (Leucht 2012), and in Butajira those who took them for under half the time died at 2.66 times the rate (Teferra 2011). In delirium, by contrast, they are not a treatment: in 247 palliative-care patients, risperidone and haloperidol made distress worse than placebo and survival was shorter on haloperidol (hazard ratio 1.73) (Agar 2017, via THRIVING library, NU-06). The cause of a delirium must be corrected instead.

Doses from two sources. The table gives MSF's guidance for low-resource settings and the US prescribing label (DailyMed) side by side. They differ widely at the top of the range.

Situation	MSF (2022 to 2024)	US label (DailyMed)	Difference
Haloperidol, psychosis, start	0.5 to 1 mg twice a day for 3 days, then 1 mg twice a day, then 2.5 mg twice a day in week 2, reassess at 2 weeks, then 5 mg twice a day if needed	Moderate illness 0.5 to 2 mg two or three times a day. Severe 3 to 5 mg two or three times a day	MSF starts lower and climbs slower
Haloperidol, maximum	15 mg a day (English), 20 mg a day (French edition)	Up to 100 mg a day 'may be necessary' in resistant cases	Large. Follow MSF
Haloperidol, old or frail	Half dose, maximum 5 mg a day	0.5 to 2 mg two or three times a day	Similar

Situation	MSF (2022 to 2024)	US label (DailyMed)	Difference
Chlorpromazine, psychosis	25 to 50 mg at night in week 1, then 50 mg morning and 100 mg night, then 100 mg three times a day	Not read	Single source [VERIFY]
Acute agitation, not on an antipsychotic	Haloperidol 5 mg with promethazine 25 mg by mouth, repeat after 60 minutes, then promethazine 50 mg IM. If hostile, IM, repeat after 30 minutes	Not compared	
Agitation in someone already on an antipsychotic	Diazepam 10 mg by mouth, or IM if violent, repeat after 30 to 60 minutes	Not compared	
Acute dystonia or stiffness	Biperiden 2 mg once a day up to 2 mg two or three times a day, or trihexyphenidyl the same	Not compared	Single source [VERIFY]
Duration	Acute psychosis at least 3 months, chronic at least 1 year, mania 8 weeks after remission. Taper over at least 4 weeks	Not compared	mhGAP: 7 to 12 months after a first episode

Sources: MSF haloperidol (updated February 2024), MSF chronic psychoses (July 2022), MSF chlorpromazine, MSF agitation, DailyMed haloperidol tablets. Haloperidol depot (decanoate) is roughly ten times the daily oral dose given monthly: 2.5 mg a day orally corresponds to 25 mg a month, 5 mg to 50 mg and 10 mg to 100 mg (MSF chronic psychoses). MSF warns against two antipsychotics together and against starting long-term drugs in people with no social support to take them (MSF chronic psychoses).

Harm and overdose. Acute dystonia (a sudden painful twisting of the neck, eyes rolling up, a locked jaw or a protruding tongue) comes in the first days and frightens families into stopping. Parkinsonism, restlessness (akathisia) and, after months or years, tardive dyskinesia (writhing of the mouth and tongue) follow. Tardive dyskinesia was found in 30.0% of people on first-generation drugs and 20.7% on second-generation drugs in a meta-analysis (Carbon 2017, abstract only). Neuroleptic malignant syndrome, with high fever, rigidity, confusion and a racing pulse, occurs in about 2 per 10,000 person-years (Guinart 2021a). In 683 case reports, 7.0% of patients on oral drugs died, and failing to stop the antipsychotic raised the odds of death 4.39 times (Guinart 2021b). Chlorpromazine causes low blood pressure on standing, heavy sedation, sunburn, poor control of body heat, dry mouth and urinary retention, and rarely a collapse of white blood cells (MSF chlorpromazine). Haloperidol prolongs the QT interval and can cause a fatal heart rhythm, especially with quinine, chloroquine or mefloquine. Phenobarbital, carbamazepine and rifampicin lower its blood levels (MSF haloperidol). Overdose brings deep sleep or coma, slow breathing, low blood pressure and the twisting heart rhythm called torsades (DailyMed). In older people with dementia, deaths were 4.5% on antipsychotics against 2.6% on placebo (DailyMed). Never give them in heart disease, dementia, Parkinson's disease or after a past malignant syndrome, and in pregnancy give the lowest dose (MSF haloperidol, MSF chronic

psychoses).

9. Chains, restraint and the record of harm

What the record shows. Human Rights Watch (2020) documented shackling of people with mental health conditions in about 60 of 110 countries surveyed, hundreds of thousands of people, some as young as ten. It interviewed over 350 people with conditions and 430 others. Shackled people eat, sleep, urinate and defecate in one spot and suffer malnutrition, infection, nerve damage, muscle wasting and trauma. Families said they had no other option. One Balinese woman's family took her to 103 faith healers. A Kenyan man was chained for five years (HRW 2020). On 6 August 2001 at Erwadi, Tamil Nadu, at least 25 people chained at a shrine died in a fire because they could not escape (Evers 2021, WHO 2017).

Restraint in hospitals kills too. In 1998 the *Hartford Courant* found 142 deaths linked to restraint or seclusion in the United States over ten years, and a Harvard estimate put the true number at 50 to 150 a year (Weiss 1998). In 168 reported cases of 'excited delirium', 62% died, and aggressive restraint was strongly associated with death, with a hobble tie (wrists to ankles behind the back) carrying an odds ratio of about 50 (Strömmer 2020). A rebuttal argues that the causal link is not proven (de Boer 2023). Of 52 restraint deaths in Sweden from 1992 to 2024, 90% happened in the prone (face-down) position and 69% involved stimulants, with profound acidosis (Tyr 2026). Restraint for many hours causes blood clots: in cohort studies 9 to 11% of restrained patients developed venous thromboembolism, more with longer restraint (Manzano-Nunez 2026). Mohr (2003) reviews the wider injuries, from aspiration to psychological trauma.

The WHO QualityRights module on ending seclusion and restraint (WHO 2017) names prone restraint as particularly dangerous because of positional asphyxia and sudden death. It lists dehydration and overheating leading to collapse, gangrene, pressure sores, incontinence, strangulation, aspiration and death in fire as harms, and attributes at least half of staff injuries in services to restraint and seclusion. It treats the belief that restraint is unavoidable as a misconception, and teaches ten domains of verbal de-escalation (Protocol 3). The MSF agitation guide says physical restraint may be used only in certain circumstances, strictly following the procedure in place.

What modern science infers. No trial of restraint is possible. The case against chains rests on a consistent record of death and injury (grade X). Brief holding by several people in a safe position, to give a drug or to stop an assault, is not the same act as tying a person down for hours or days, and the record of death concentrates in prone holds, chest pressure, long restraint, intoxication and fire. A village rule on who may hold, how, and for how long is the owner's decision [OWNER].

Evidence grades

Practice	Grade	Basis
Family intervention and psychoeducation	A	Pharoah 2010, 53 trials, poor quality
Antipsychotic maintenance to prevent relapse	A	Leucht 2012
Gradual taper rather than abrupt stop	B	Viguera 1997, Leucht 2012 disagrees
Guided dose reduction after a first episode	A for higher early relapse, B for better long-term function	Wunderink 2007, 2013, one trial
Collaboration with healers and primary workers	A	Gureje 2020, one trial
Lay community care (COPSI)	A for small effect	Chatterjee 2014

Practice	Grade	Basis
Soteria house care with little drug	B, approaching A	Bola and Mosher 2003, Calton 2008, small samples
Open Dialogue	B	Bergström 2018, Freeman 2019, no trial
Family foster care on the Geel pattern	B to D	Linn 1980 for foster care, nothing measured at Geel
Moral treatment recovery figures	B, inflated	Evers 2021, Earle 1887
Searching for a physical cause first	B	MSF, Agar 2017
Verbal de-escalation	B to C	WHO 2017, no trial read
Antipsychotic for delirium in the dying	X	Agar 2017
Chains, shackles, prone or prolonged restraint	X	HRW 2020, Strömmer 2020, Tyr 2026
Abrupt stop of a long-term antipsychotic	X	Viguera 1997

Means ledger

Rung	What can be done	What it changes
Hands and knowledge	Recognise delirium and its warning signs. Company and a calm voice. De-escalation. Watchers in pairs. No chains, no prone holds. Family taught to lower criticism	Prevents the restraint death, the fire death and the missed delirium. Family work alone halves relapse in trials (Pharoah 2010)
Hearth	Quiet room, mattress on the floor, light at night, food and water offered often, warmth, a thermometer if salvaged, written plan when well	Treats the hunger and dehydration that killed the untreated in Butajira and Bali. Detects fever
Garden and still	Niacin-rich food against pellagra, a scale to weigh tablets, records kept by a literate keeper, knowledge of Datura to remove it from gardens	Prevents pellagra psychosis and Datura delirium. Allows dose counting
Village dispensary of 300	A trained lay healer, a small salvaged stock of haloperidol, biperiden and diazepam under the CH-04 stock rule, a microscope for a malaria film, a safe room, a watcher rota	Antipsychotic cuts relapse by 60% and early death (Teferra 2011). Malaria film separates cerebral malaria from psychosis [OWNER: whether the village may start an antipsychotic or only continue one]
District infirmary of 3,000	A nurse or doctor, a sterile room, ten beds, one bed held for acute psychosis, injectable haloperidol and diazepam, lab bench for blood sugar and malaria, depot injections, a stock for 25 patients	Safe management of severe agitation, mania and postpartum psychosis. Identifies infection. Planned tapers

Rung	What can be done	What it changes
Hospital before the Fall	Psychiatric team, ECG for QT, blood counts, brain imaging, lithium with blood levels, clozapine with blood monitoring, ICU for neuroleptic malignant syndrome	Treatment-resistant illness, safe lithium, survival of malignant syndrome. None of this is available after the Fall

Harm test

Family and village care. It kills by neglect: the person who is not fed, not washed and not taken to the district when feverish dies of infection or hunger, as in Butajira (Teferra 2011). It kills by abandonment: suicide is highest early in the illness. It maims by chains, by isolation in an outhouse and by beating, as under the Church at Geel (Jay 2014). Signs it is going wrong: weight loss, sores, a locked door, a person no longer seen at meals. What to do then: the district visits, and the owner's rule on confinement applies [OWNER].

Restraint. It kills by positional asphyxia face down, by pressure on chest or neck, by heat and exhaustion in a struggling person, by aspiration, by blood clots after hours tied, and by fire when the person cannot get out (WHO 2017, Strömmer 2020, Manzano-Nunez 2026). Highest risk: the intoxicated, the obese, the feverish, the exhausted and children [VERIFY: risk groups from the forensic series, not a single source]. Signs: silence after struggle, gurgling breathing, blue lips, a limp body. What to do: release at once, turn on the side, open the airway.

Antipsychotics. Their harms, overdose signs and exclusions are in Section 8. The commonest errors: giving one to a delirium, two together, a high dose to an old person, and an abrupt stop (MSF haloperidol, Agar 2017, Viguera 1997). Misidentification: salvaged tablets must be identified by the printed strip, not by colour [VERIFY: own rule].

Soteria-style care without drugs. It harms when the episode is a delirium, when the person is suicidal and unwatched, when watchers are exhausted and become rough, and when a person who would have recovered on a drug is kept ill for months [VERIFY: own inference, not tested].

Historical cases of harm. The Erwadi fire of 2001 (25 dead in chains), the 142 restraint deaths reported in the United States 1988 to 1998, and the Ethiopian and Balinese cohorts with deaths at about 35 (Evers 2021, Weiss 1998, Teferra 2011, Kurihara 2011a).

Red flags

These signs mean the person may die or be disabled without what the village cannot give. Send to the district at once, and if that is impossible, give the care listed.

1. **Fever, stiff neck, drowsiness or fits with new confusion.** Meningitis, cerebral malaria or typhoid. Treat as infection (THRIVING library, IN-11). Do not give an antipsychotic first.
2. **Fever with rigidity after starting or raising an antipsychotic.** Neuroleptic malignant syndrome. Stop the drug, cool, give fluids by mouth if the person can swallow, and transfer (Guinart 2021b).
3. **Hot, dry, flushed skin, wide pupils and picking at the air.** Datura or another anticholinergic. Watch, cool, give no antipsychotic, and expect 24 to 48 hours (THRIVING library, CH-03).
4. **Psychosis within weeks of childbirth.** Risk to mother and baby. Check for fever and blood pressure first. Never leave mother and baby alone together until the district has seen her.
5. **Talk of death, a plan, or a past attempt.** Lifetime suicide is about 5%, highest near onset (Palmer 2005, Hor and Taylor 2010). Constant watch, remove means.
6. **Refusing food or water for more than a day.** Dehydration kills faster than the psychosis.

7. **Violence with a weapon.** Clear the space, do not corner, call more people, and use the owner's rule [OWNER].
8. **A person chained or locked away anywhere in the village.** This is the village's red flag, not the patient's.

Honest comfort: a first episode of psychosis often remits, perhaps half of people recover over the long term (Harrison 2001), and a person can live a full life in a village with a role and a family that does not reproach them. Where the illness is chronic, comfort lies in company, food, work and a dignified place, not in cure.

The case against

Against the romance of the village. Cohen, Patel, Thara and Gureje (2008) and Burns (2009) argue that the 'better outcome' finding has been misread to mean that poor rural places heal psychosis. The mortality cohorts (Teferra 2011, Kurihara 2011a, Thara 2004) show early death in the same settings. Human Rights Watch (2020) shows that village tolerance coexists with chains. Earle (1887) showed that the moral-treatment cures were counting errors, and Evers (2021) that its founders used restraint.

Against the romance of the drug-free house. Soteria's trials are small, partly non-random and analysed on completers. Open Dialogue has no randomised trial, and its Lapland population is small, homogenous and well served (Freeman 2019). Leucht (2012) shows that two thirds of people relapse within a year without a drug, against a quarter with one. Withholding a drug from someone who would respond to it may prolong suffering, a cost these designs cannot measure [VERIFY: own inference].

Against the romance of the drug. Wunderink (2013) and Harrow and Jobe (2007) suggest that long-term maintenance does not suit everyone. Tardive dyskinesia affects a quarter of long-term users (Carbon 2017). After the Fall, a drug that will run out is a promise that cannot be kept, and its abrupt end may harm more than never starting it (Viguera 1997). MSF itself advises against starting where no one can supervise taking it.

Where this leaves the village. Old does not mean safe: Geel chained, the Retreat restrained and the asylums inflated their cures. Modern does not mean replaceable: in Butajira, people who took an antipsychotic less than half the time died at 2.66 times the rate.

10-line summary

1. A village of 300 holds two or three people with severe mental illness, and a district about 25.
2. Some developing-country centres had better symptom outcomes (WHO studies), but rural people with psychosis die 20 to 30 years early, mostly of infection, hunger and suicide.
3. Family intervention halves relapse (NNT 7) and costs only time.
4. Antipsychotics cut one-year relapse from about 64% to 27% (NNT 3).
5. After an abrupt stop, half relapse within 30 weeks. Taper over at least four weeks while stock remains.
6. A minority of first-episode patients do well on low doses or none, and cannot be picked in advance.
7. Soteria and Open Dialogue show that company and a quiet house can carry some first episodes with little drug, on small or uncontrolled samples.
8. Geel shows family foster care can last centuries, with payment, a hospital behind it and, in its past, chains.
9. New confusion with fever, drowsiness, childbirth, poison or injury is a body illness until shown otherwise.
10. Chains and prone restraint kill. Any hold must be brief, face up or on the side, and decided by rule [OWNER].

Open questions

- Does family foster care in Geel produce better outcomes than family care at home? No data were found.
- Is the active ingredient of lay care supervision or the paid role? MI-01 and MI-02 disagree. Geel is consistent with both and settles neither.

- Can a lay village healer start an antipsychotic safely, or should only the district? No trial tested lay initiation [OWNER].
- How long do salvaged haloperidol and chlorpromazine tablets keep their potency? No antipsychotic-specific stability data were found (THRIVING library, ME-09).
- Which first-episode patients can stop safely? Wunderink's one trial has not been replicated at seven years.
- Do plant sedatives such as *Rauvolfia serpentina* (Indian snakeroot, root, the source of reserpine) have a place? Not researched for this report [VERIFY].
- What are the true Worcester and Retreat recovery rates once readmissions are removed? Bockoven 1956 and Tuke 1813 were not read.

Sources to read in full

1. Harrison 2001, the ISoS 15- and 25-year follow-up.
2. Cohen, Patel, Thara and Gureje 2008, 'Questioning an axiom'.
3. Teferra 2011, five-year mortality in Butajira.
4. Bola and Mosher 2003, the Soteria two-year outcomes.
5. Pharoah 2010, the Cochrane review of family intervention.
6. Wunderink 2013, seven-year follow-up of dose reduction.
7. Goldstein and Godemont 2003, the Geel legend and lessons (not read for this report).
8. WHO 2017, the QualityRights module on ending seclusion and restraint.
9. Evers 2021, the varieties of 19th-century moral treatment.
10. MSF clinical guidelines, chronic psychoses and agitation.

At the bedside after the Fall

Household. Minimum: keep the person fed, watered, warm and in company, in a quiet room with a mattress on the floor. Look for fever and confusion first. No chains, no locked outhouse. Learn the early warning signs of relapse when the person is well (sleep loss, withdrawal, suspicion, odd speech) and write them down. Needs to start: a second adult, a quiet room, a thermometer if salvaged, a notebook. First failure to expect: exhaustion of the family within three to five days of an acute episode, leading to rough handling or a chain [VERIFY: own estimate].

Village of 300. Minimum: a named lay healer trained in this report, a watcher rota of at least six adults for an acute episode [OWNER: whether watchers are paid or owed labour, see MI-01 and MI-02], a safe room, a family meeting every week during and after an episode, and a written plan for each person with a severe mental illness. A small stock of haloperidol and biperiden held under the CH-04 stock rule. Needs to start: training, a room with nothing hard or sharp, a register, the stock. First failure to expect: a delirium (fever, poison or childbirth) called madness and given haloperidol.

District of 3,000. Minimum: one bed and one trained nurse for acute psychosis, injectable haloperidol and diazepam, a malaria film, the decision on starting and stopping antipsychotics [OWNER], a register of about 25 people and their stock, and visits to each village twice a year. Needs to start: the register, the stock rule, a way to carry a person who cannot walk. First failure to expect: stock running out without a planned taper, causing relapse in many people within months.

Protocols

Protocol 1. The first hour: body or mind? - [ ] Take the temperature, or feel the skin with the back of the hand. Fever means infection until shown otherwise (Red flags 1). - [ ] Ask the person's name, the place and the time of day. Wrong answers, drowsiness or a fluctuating state mean delirium (MSF). - [ ] Ask the family: onset in hours or in weeks? Recent childbirth, fit, fall, new medicine, alcohol, plants eaten or smoked? - [ ] Look at the pupils and skin. Wide pupils with hot dry skin means Datura or another anticholinergic. - [ ] Look at the skin of the hands, neck and

face for the dark scaly rash of pellagra. - [ ] Check the bladder. A full bladder makes people agitated (THRIVING library, WO-07). - [ ] In a malaria area, send blood for a film or treat as malaria. - [ ] Only if all are negative, treat as a primary psychosis or mania.

Protocol 2. The watch at home - [ ] Two watchers at all times during an acute episode, one of them known to the person. Shifts of no more than four hours [OWNER: rota, payment, who may refuse] [VERIFY: shift length is the author's proposal]. - [ ] A ground-floor room with a mattress on the floor, no blades, cords, glass or fire within reach, and an open door. Low light at night, never darkness. - [ ] Offer water every hour and food three times a day. Record what goes in. - [ ] One quiet visitor at a time. No arguing with the beliefs, no mocking, no crowd. - [ ] Keep a written note each shift: sleep, food, threats, talk of death.

Protocol 3. De-escalation (WHO 2017, ten domains) - [ ] Keep two arm lengths away and leave the person a way out. - [ ] Hands visible, stand at an angle, no sudden moves. - [ ] One person speaks. Introduce yourself. - [ ] Short sentences, repeated. - [ ] Ask what the person wants and how they feel. - [ ] Listen closely and say back what you heard. - [ ] Agree where you can, or agree to disagree. - [ ] Set clear limits calmly: "I can't let you hurt anyone." - [ ] Offer choices (water or tea, sit or walk) and hope. - [ ] Afterwards, talk it through with the person and the watchers.

Protocol 4. Holding when there is no alternative [OWNER] The owner decides whether holding is allowed at all, who may order it (two named adults is the author's proposal), for how long, and how it is recorded [OWNER]. - [ ] Only to stop an assault, to stop self-harm or to give a drug the district has ordered. - [ ] At least four people, one per limb, one leader who speaks to the person throughout. - [ ] Face up or on the side. Never face down, never a knee on the back, chest or neck, never wrists tied to ankles (WHO 2017, Strömmer 2020). - [ ] Watch breathing and lip colour the whole time. Release at once if breathing changes or the person goes quiet and limp. - [ ] Release within minutes, not hours [OWNER: maximum time] [VERIFY: no source read gives a figure for village holding]. - [ ] No chains, ropes or locked rooms at any time [OWNER: whether the village bans them outright]. - [ ] Record who held, why, how long, and any injury.

Protocol 5. Using a salvaged antipsychotic - [ ] Decided by the district, or by the village healer only if the owner allows [OWNER]. - [ ] Not in a delirium, not with fever, not in heart disease or dementia, not with Datura. - [ ] Haloperidol: 0.5 to 1 mg twice a day for 3 days, then 1 mg twice a day to day 7, then 2.5 mg twice a day in week 2. Reassess at 2 weeks. Never more than 15 mg a day (MSF). Old or frail: half dose, maximum 5 mg. - [ ] Watch for twisted neck, rolled eyes or locked jaw. Give biperiden 2 mg and continue it as needed (MSF). - [ ] Fever with stiffness: stop the drug, cool and transfer (Red flags 2). - [ ] Continue at least 3 months after an acute episode and 1 year if chronic (MSF).

Protocol 6. Tapering and the stock rule [OWNER] - [ ] Follow the CH-04 stock rule: no new long-term patient unless 12 months plus a 3-month taper are held. Below 6 months of stock, begin planned tapers. Below 3 months, taper everyone (THRIVING library, CH-04). - [ ] At haloperidol 5 mg a day, one person needs about 365 tablets of 5 mg a year and about 45 more for a 3-month taper [VERIFY: own arithmetic]. - [ ] Taper over at least 4 weeks, preferably months, cutting by about a quarter at each step [VERIFY: step size is the author's proposal, MSF gives only the total time]. - [ ] At each step, the family watches the early warning signs written down when the person was well. If they return, go back to the last dose and reduce more slowly (MSF). - [ ] Count stock monthly, in pairs, and record every tablet out (THRIVING library, CH-04).

Numbers to carry

1. **2 to 3** people with severe mental illness in a village of 300.
2. **64% against 27%**: one-year relapse off and on an antipsychotic (Leucht 2012).
3. **50% within 30 weeks**: relapse after an abrupt stop (Viguera 1997). Taper over at least **4 weeks**.
4. **NNT 7**: family intervention to prevent one relapse (Pharoah 2010).
5. **0.5 to 1 mg twice a day** to start haloperidol, **15 mg a day** maximum (MSF).

6. **About 5%** lifetime suicide in schizophrenia, highest near onset (Palmer 2005).
7. **Death at about 35**: the mean age at death of people with schizophrenia in rural Ethiopia and Bali, mostly from infection and hunger (Teferra 2011, Kurihara 2011a).
8. **90%** of Swedish restraint deaths were face down (Tyr 2026).
9. **Hours, not weeks**: a delirium starts in hours and fluctuates. A psychosis builds over days to weeks in a clear mind.

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