From Bedlam to 'care in the community'

Reimagining mental healthcare from a homeopathic perspective

by Rix Pyke RSHom

Rix Pyke trained at the Devon School of Homeopathy (qualified 1998) and the Guild of Homeopaths (2001). She works in her private practice in South London and since 2001 has worked once a week in a mental health project nearby. In 2010 she was part of forming a collective of alternative practitioners from the project which now receives funding to provide therapies to people in and out of psychiatric care. She also teaches Qi Gong privately and in the acute psychiatric wards as part of a wider project to promote holistic health.

Pharmaceutical psychiatry has lost its way. Shuffling after the illusion of its magic-bullet cures, it has created the nightmares of the 'revolving door syndrome' and the iatrogenic disease-creating hell that fills our mental hospitals and dumps poor-outcome patients onto the benefit system for the rest of their lives.

Hahnemann saw that 'such unfortunate beings' (*Organon*, #222) were living chained and beaten and tortured but he could also see 'the soul that pines or frets in the chains of the diseased body', (#229) a reminder of what our work is today. He made an early discovery of the power of *Stramonium* in psychosis with a dramatic cure of a patient, Herr Klockenbring (*Lesser Writings*) and advocated treatment 'by mildness rather than coercion'.

For the past 15 years I have been imagining how things could be different. In this article I advance a new approach using the homeopathic perspective which allows no separation between mental, emotional or physical health because this separation leads to the sorry state of modern day acute psychiatric Evidence Based Medicine (EBM).

Mental illness is extremely difficult to manage. When someone has a raging temperature and is coughing themselves into a bronchitis or even a pneumonia, they at least have the decency to stay in bed and be administered to. In the acute phase, psychosis is horrible to experience and frightening to behold. Anyone subjected to it would wish to subdue it, to suppress it or just to go to sleep and hope it would go away.

If you have ever watched a loved one becoming psychotic there is only one thing you want: you want them to be taken somewhere else and kept safe and you want them to be able to sleep because you can no longer bear to see them suffer. While they are manic and sleepless your home, your family, your health and your ability to go to work and function are all made impossible. You just want them taken away.

But 'away' is not all it's cracked up to be. 'Away' is a Section under the Mental Health Act 1983 which must be made by a mental health professional or 'your nearest relative'. Families at breaking point have little choice but to offer their loved one up to be sectioned. Section 2 allows for up to 28 days being locked in a ward for assessment and treatment. Section 3 is for six months at a time. The most sinister aspect of this Section is that *you do not have the right to refuse treatment*.

While the pharmameds are the only treatment available the lamb of basic good health has been slaughtered and laid on the altar of EBM. Fundamental understanding of what we need to begin a journey back to health has been lost. In Hahnemann's words a 'carefully regulated mode of life' (#228) is what needs to be developed.

Where did health go?

In the industry that is called 'mental health' the 'health' got left behind and the 'mental' rules supreme. Somewhere in the frenzy of EBM (in the notion that the chemical imbalances in the brain are the disease itself) modern psychiatry – along with allopathic medicine as a whole – started running after the elusive dopamine receptors, serotonin reuptake inhibitors and any of the other chemical causes of madness.

The only treatment on offer for acutely ill patients in NHS psychiatric hospitals is pharmaceutical medication, and so begins the cascade of intervention and the multi-million-dollar industry of 'doctoring the mind' (Benthall, 2009).

The cuckoo's nest

In 1975 I saw the Jack Nicholson film *One Flew over the Cuckoo's Nest* and remember the horror

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The interior of Bedlam (Bethlem Royal Hospital), from *A Rake's Progress* by William Hogarth, 1763

with which it was greeted. It showed a mental health regime of forced injections, incarceration, violence, inhumane treatment and electro-convulsive therapy. In my experience, 40 years later nothing has improved and in many ways the situation has deteriorated. At least in Jack's ward they had access to sunlight and fresh air, an exercise yard and a sunny spacious ward.

The six basic things we need to be healthy are: good water, good food, access to sunlight and to fresh air, good sleep and exercise. In the wards that I have worked on these basics are often not available.

Water fountains are sometimes broken, smashed up by an enraged patient. Often there are no cups available and sometimes the water is in inaccessible, locked parts of the ward.

The food in hospitals is denatured, pre-cooked, over-cooked, and often microwaved. Access to fresh fruit and raw food is almost nil. Tea and coffee with sugar are the only hot drinks available and I have watched while a highly agitated patient spoons sugar into his cup of instant coffee and then is medicated with stronger tranquillisers to manage his mood.

Access to sunlight and fresh air is virtually impossible for many patients on these locked wards as only those who smoke are taken down to the 'gardens', some of which are sunless yards or car parks. One acute psychiatric ward on the third floor of a big London Hospital had NO fresh air – all the windows had been screwed shut to prevent women throwing themselves out. It was on that ward where a woman patient explained to me that she had to *become* a smoker in order to be allowed down to get fresh air.

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Sleep and exercise are key to returning equilibrium to our systems and when we are ill we need sleep more than anything. Sleep is the key to becoming well again but gentle, healing exercise is the 'yang' to sleep's 'yin'. When we are sleepless we become far more susceptible to acute illness or the acute flare-ups of our underlying chronic conditions. In the acute psychiatric wards I see patients turn from having intense vitality, which is seen as the mental illness they are diagnosed with, to such heavy drugging that they become incontinent, can hardly walk, can barely keep their eyes open and cannot do even the simplest exercise. Their sleep / wake patterns become sleep / sleep.

The revolving door

Many kind people work in the field of mental health, and enormous efforts are made to keep people as safe as possible while in the hospital. But the fundamental basis of health has been completely lost while all the money and focus is placed on the pharmaceutical medication of patients in acute crisis. The drugs used are hooking patients into a pattern of dependency where readmissions come faster and more furiously as the prescriptions become stronger and stronger.

Robert Whitaker, in his study of the treatment of mental illness, explains that schizophrenia patients discharged on medications were returning to psychiatric emergency rooms in such droves that hospital staff dubbed it the 'revolving door syndrome'. Even when patients took their medications reliably, relapse was common, and researchers observed that 'relapse is greater in severity during drug administration than when no drugs are given' (Whitaker, 2011).

In a history of the Bethlem Royal Hospital, an interesting point is clearly made that, although medical treatment for insanity was largely ineffective throughout this time (18th and 19th centuries), patients did, in fact, recover.

This is a far cry from today's statistics where the use of antipsychotic drugs (Largactyl) produce a rapid cycling, constantly relapsing population of people with 'poor outcomes and disability with cognitive decline' (Whitaker, 2012).

This forms a whole new group of the apparently long-term mentally ill, who are in fact the long-term iatrogenically disabled, whom we see shuffling in and out of our mental hospitals and 'care' in the community.

Robert Whitaker, in his book *Anatomy of an Epidemic*, reports on a World Health Organization (WHO) study comparing developed and undeveloped countries' outcomes for people with schizophrenia which found that:

> 63.7% of the patients in two poor countries were doing fairly well at the end of two years. In contrast, only 36.9% of the patients in the U.S. and six other developed countries were doing fairly well at the end of two years.
> (Whitaker, 2011)

The researchers concluded that 'being in a developed country was a strong predictor of not attaining a complete remission'.

Although the WHO researchers did not identify a variable that would explain this difference in outcomes they did note that, in the developing countries, only 15.9% of patients were continuously maintained on neuroleptics, compared to 61% of patients in the U.S. and other developed countries.

A National Institute of Mental Health (NIMH) study looked at one-year outcomes for 299 patients who had been treated either with neuroleptics or placebo upon their

admission to a hospital and the researchers found that patients who received placebo 'were less likely to be rehospitalised than those who received any of the three active phenothiazines' (*British Journal of Psychiatry*, 1968).

In *Anatomy of an Epidemic* Robert Whitaker explains how the drug trials (RCTs) on the use of anti-psychotic drugs on people suffering a psychotic episode looked only at the short-term shape of peoples' lives, neglecting the long term.

As with antibiotics, when anti-psychotics were first used they seemed to magically empty the hospitals. Symptoms abated under the influence of these new wonder drugs but, in cases where the patient stopped taking them, they found the relapse rate was far greater. From this they concluded that people must be on the drug for life.

What they omitted to show was that the relapse rate was *one third* as great in the group that withdrew gradually. So tapered withdrawal is the KEY to long-term good outcomes. However, it requires more time, needs more support and is not what the drug companies want in the long run. Instead we have a whole new population of people who are not mentally ill but who are suffering from disability caused iatrogenically by the anti-psychotic drugs themselves.

This is where homeopathy can support patients wishing to work with their psychiatrist or GP in starting the gradual, supported and crucial work of coming off their medication. We need to ignore the medications as we do not prescribe them and therefore we do not de-prescribe them either. We need to work to manage ROOS (return of old symptoms), support skin eruptions and encourage the journey back to real health from the mental and emotional level and out through the physical. As mental clarity returns and insight into their condition and the vitality from the remedies starts to kick in, so the patient can begin to see what path they wish to take. Homeopaths do not need to lead anyone anywhere. We just follow and, if it is towards a drug-free future, then we need to ensure that the patient is supported in doing it as gradually and as slowly and as carefully as they can.

Bethlem to care in the community?

Historically, how Bethlem operated was by keeping patients for 12 months, after which time most had recovered. The rest were termed 'incurable' and moved to long-term care.

Barbara Taylor, in her autobiographical account of being taken to one of London's last mental asylums in the late 1980s, experienced it as 'a refuge and a home'; in the true sense of the word she experienced some 'asylum'. In *The London Review of Books* (2014) Jenni Diski describes

> the late 18th-century movement to reimagine the mad: places with decent optimistic conditions of airiness and light were built to house them and they were recast from Calibans to patients to be treated with rationality and humanity. Then, with a loss of interest in weakness and need, and the collapse of the idea of progress, the monumental asylums became monstrous institutions, dilapidated, overcrowded, with back wards inhabited for decades by neglected, tormented patients, the broken-down state of the fabric echoing the casual brutality of many of the staff and very little in the way of therapy apart from the chemical cosh.

It was at this point in the 1990s that the closure of the asylums made way for the creation of mental disability, acute wards and care in the community.

So what should we be offering people in acute mental crisis? As Whitaker says:

> We need a form of care that allows for the possibility that we would do better without the meds.

The treatment of acutes

Without a vision we become like the NHS today – a huge, hungry, monstrous creature flailing around without direction or understanding, howling to the government that it needs more and more money while it tramples unwittingly on the very foundation of our health: the treatment of acute illness.

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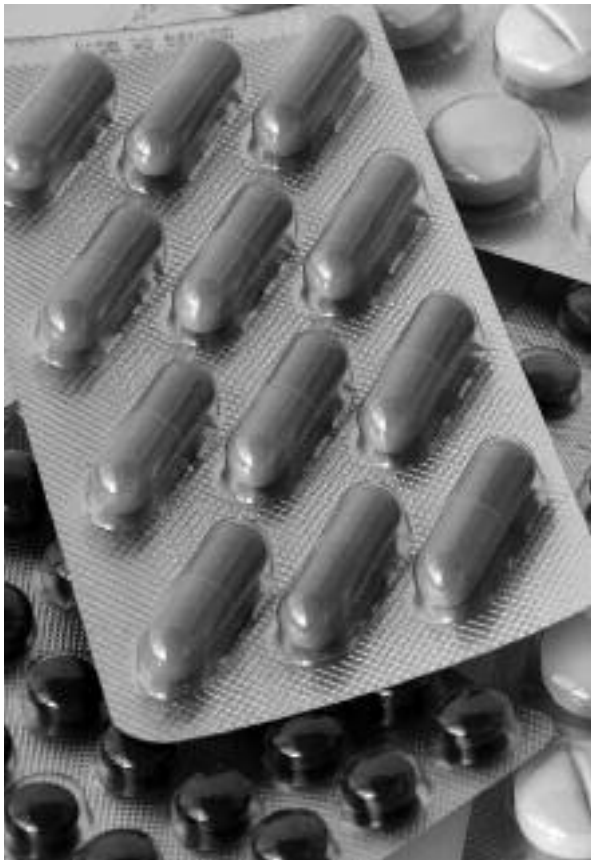
Scene from *One Flew Over The Cuckoo's Nest* – what a notion! A sunny exercise yard and basketballs! If only …



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The use of anti-psychotic drugs produces a rapid cycling, constantly relapsing, population of people

Homeopaths understand and embrace the importance of the correct treatment of acute illness – be it mental, emotional or physical – and that alone could revolutionise mental health care and reverse the poor outcomes that the suppressive and long-term drug industry create.

In homeopathy there is no distinction between acute mental illness and acute physical illness. If they are treated correctly the person returns to equilibrium having raised their level of health. If they are suppressed the illness goes deeper and affects more profoundly the overall health of the person. When I have taken the cases of the patients who have ended up caught in the cycle of recurring hospital admissions and stronger and stronger medication there is always a point on the timeline where too much heavy-handed suppression of an acute flare-up has led to a raised susceptibility. The pressures of poverty, racism, loneliness, bereavement, raising teenagers or hormonal dysfunction and so on just tipped the person into an acute state of mental, emotional and physical breakdown and then the cascade of intervention took over and the patient lost all control.

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➢ **'Where there is no vision the people perish' (*Proverbs* 29 – 18)**
It does not need to be like this. The Soteria Project in California offered community alternatives for the treatment of schizophrenia. Started by Loren Mosher it was instrumental in developing and researching an 'innovative, home-like, residential treatment facility for acutely psychotic persons' from 1970-1992 which showed that

> there is a better way: a better way to treat schizophrenia and other psychoses that destroy the lives of so many young people.

The Soteria research showed that 'the prevalent excessive destructive psychiatric drugging of all these young people is a huge and tragic mistake' (Soteria, 2009). In the project they did use medication in the form of benzodiazapines (Valium and so on) to encourage sleep / wake patterns to return – but only very short-term use with tapered withdrawal, which meant the outcomes of those patients did not lead to life-long disability and medication.

3D vision
What would a service where health was understood to comprise mental, emotional and physical health be like? Where the present day psychiatric acronym of the 3Ms (Manage, Medicate and Move on) was replaced by a 3D vision (De-stress, De-tox and De-velop)?

What would a 3D ward look like? The collective of therapists I work with developed our vision of an ideal 3D ward. It includes the basic needs: access to drinking water and encouragement to drink it, access to sunlight and fresh air and a garden, holistic and healing exercise, meaningful therapeutic conversations, access to non-pharmaceutical therapies and food which was fresh and high in vitamins, minerals and EFAs.

Instead of the medications round three or four times a day there would be water, raw food and supergreens available to all the patients in order to attempt to reboot their basic levels of health and nutrition.

The team on the front line in the acute psychosis unit would consist of a multidisciplinary team with a staff group feeding back information regarding sleep, self-care, EE (expression of emotion) and discharge. Discharge in the homeopathic sense, meaning the attempts made by the body and psyche to discharge physical, emotion and mental 'waste products' or long held toxicity.

In homeopathy there is no distinction between acute mental illness and acute physical illness

The team of practitioners would work to integrate their understanding of the patient's dis-ease, and appropriate treatments would be offered for the patient to start to make some health choices which make sense to them and their families and carers.

The case-taking would be on the homeopathic model, the timeline would be shared. In a paper entitled *The Homeopathic Healing Process, Transformational Outcomes and the Patient-Provider Relationship* Iris Bell and Mary Koitan's conclusions point to the homeopathic process having 'the capacity to trigger transformative change and the role of the homeopath in facilitating and supporting the process'. It is interesting to note that today's ward admissions take almost no history, put the patient in very little context and unsurprisingly make no timeline.

While access to allopathic drugs would be a last resort, and most importantly be short-term, homeopathic remedies would play their part in supporting the patient in their return to sleep / wake equilibrium and bringing the centre of gravity of the dis-ease down to the physical level.

Final thoughts

In conclusion, I hope that as homeopaths we stay true to our understanding that there is no separation between health and mental health. Keeping that clear we can take every case as it comes, refuse to fall prey to the ubiquitous 'diagnoses' offered in the *Diagnostic and Statistical Manual* (*DSM*) where, as Allen Francis writes in *Psychology Today* (2012):

> Many millions of people with normal grief, gluttony, distractibility, worries, reactions to stress, the temper tantrums of childhood, the forgetting of old age, and 'behavioural addictions' will soon be mislabelled as psychiatrically sick and given inappropriate treatment.

To end, I would like you to have the programme values of the Soteria Project. If we add a frontline of holistic treatments, nutritional and herbal supplementation and homeopathic case-taking and prescribing, a new paradigm in healthcare can be born:

- Do no harm.
- Treat, and expect to be treated, with dignity and respect.
- Be flexible and responsive.
- In general the 'user' (client, patient) knows best. We each know more about ourselves than anyone else. This is usually a vast untapped reservoir of valuable information.
- Choice, the right to refuse, informed consent, and voluntarism are essential to programme functioning. Without options, freedom of choice is illusory. *Involuntary treatment should be difficult to implement and used only in the direst of circumstances.*
- Expression of strong feelings and development of potential are acceptable and expected – and are not usually signs of 'illness'.
- Whenever possible, legitimate needs (for example, housing, social, financial) should be filled. *Without adequate housing, mental health 'treatment' is mostly a waste of time and money.*
- Risks are part of the territory; if you don't take chances nothing ever happens.

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The team of practitioners would work to integrate their understanding of the patient's disease

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