

Staying Relevant With the Times—The Changing Face of an Asylum

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Last year, the Institute of Mental Health (IMH) celebrated its 85th anniversary. From its origins in 1928 as what was then simply called The Mental Hospital, this nondescript name was later changed in 1950 to Woodbridge Hospital.¹

The establishment of the Mental Hospital was at a time when there was no effective treatment for mental illness. The only humane option at the time was “moral treatment”, which meant kind, individualised treatment in the form of occupational therapy, exercise, and recreation in a sheltered environment. The hospital was, in fact, an asylum in the original meaning of the word: “a refuge, protection, or sanctuary”.

This humane idea of looking after the mentally ill reached its apotheosis in America when the early mental hospitals built in the 19th century took the form of large, stately buildings, with large sprawling grounds and comfortable accommodation that also created a sense of community and companionship for the patients. There were farms and dairies that provided therapy for the patients in the form of work, and these agricultural activities also helped to sustain the running of the hospitals.

Antipsychiatry Movement

However, it was also in America where the page turned with the precipitate decline of this high-minded ideal. An influx of an increasing number of patients and shortage of funds strained these mental hospitals to their limits and forced them to closure. Within a few decades, most morphed into “warehouses” for the mentally ill, and became synonymous with neglect, misery and abuse.

Journalistic exposé of the appalling conditions of these hospitals whipped up a sense of public revulsion and outrage, which was further stoked by Ken Kesey’s novel ‘One Flew Over the Cuckoo’s Nest’ and the subsequent blockbuster movie with its graphic depiction of the sequential brutalisation of a wayward patient at the hands of the staff of a mental hospital.

As described by the historian Edward Shorter, there was a time in the early 1960s that, in an almost concerted move in certain intellectual circles, a series of influential books were published, speaking against the practice of psychiatry.² Sociologist Erving Goffman’s ‘Asylums’, portrayed asylums as “total institutions”, that deprived patients of their autonomy, imposing rigid rules that further humiliated and constrained them, creating a gulf between staff and patients. Michael Foucault’s ‘Madness and Civilization’ argued that the notion of mental illness was a social and cultural invention. Thomas Szasz’s book, ‘The Myth of Mental Illness’, called the whole notion of psychiatric illness “scientifically worthless and socially harmful”, and that mental illness was simply a myth. In the United Kingdom, Ronald D Laing’s ‘The Divided Self’ presented schizophrenia as a rational response to intolerable experiences and argued the psychotic symptoms were assumed to “throw dangerous people off the scent.” The gist of their collective arguments which fueled the antipsychiatry movement was that mental illness is not medical in nature and that it does not exist other than as social, political, and legal constructs deployed to exert control over certain members of society.

Deinstitutionalisation

What initiated the subsequent massive closing down of mental hospitals and the exodus of patients to the community, a process known as deinstitutionalisation, was the increasingly strident and vociferous antipsychiatry movement, and the discovery of antipsychotic drugs in the 1950s, which greatly ameliorated the disruptive behaviour of patients and held the promise of returning patients back to their families and communities.

In theory, deinstitutionalisation is the transfer of care of mentally ill patients from these long-stay mental hospitals to smaller community-based alternatives.³ It also requires the shunting of potential new admissions to these mental

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hospitals to alternative facilities, and the development and installation of special services in the community for the care of these patients.⁴

It was also widely assumed that community-based care would be more humane, therapeutic, and cost effective.⁴⁻⁶ But in practice and in reality, things did not work out that way. The communities were ill-prepared and ill-equipped to receive and support the burgeoning number of discharged patients. Many of these patients had been institutionalised for such a long time and had become so accustomed to a highly structured and sheltered living environment that they were incapable of independent living outside the hospital.⁷ These hastily discharged patients, bereft of shelter, became homeless, and in full view of an intolerant and fearful public, were often picked up by the police. Many landed in prisons rather than in hospitals, resulting in what was subsequently called “a criminalisation of mentally disordered behaviour” which is the diversion of mentally ill persons who need treatment into the criminal justice system instead of the mental health system.⁸

Perhaps the American experience with deinstitutionalisation held some salutary lessons for us, for there was no parallel massive deinstitutionalisation in Singapore, and perhaps, the time for it was not right. In a somewhat contrarian move, the foundation was laid for a new and bigger mental health facility in 1988, which in 1993, became the present IMH and the old Woodbridge Hospital was eventually torn down.

With better knowledge, experience, and with some advances in treatment (both pharmacological and psychosocial), as well as a change in the way mental health and mental illnesses are viewed by the public and policy makers, there is now the political commitment to further develop and expand the community treatment of the mentally ill. These include early detection mechanisms, with involvement of the primary healthcare sector and other community care providers, which could have the potential to attain recovery and preservation of mental function, even for those with serious mental illness, and prevent the deterioration to that state when institutionalised care is needed.

In 2007, Singapore implemented the first National Mental Health Policy and Blueprint to promote mental health, and restructure the delivery of mental health care in all the sectors and levels—from the hospitals to the community. We are now in the second phase of our National Mental Health Blueprint and an important component of which is to further develop the range of services across the various healthcare and social sectors for community healthcare. The IMH is also striving to reduce its large population of patients who have been long institutionalised. This is well and good, but despite what we do, there are limits.

We hear often that plaintive question asked by elderly parents of what would happen when they are no longer able to look after their mentally disabled offspring; we hear this from any despairing caregiver who has reached the end of his or her tether as well. As a result of the incomplete knowledge and the limitations of our current treatments despite the advances in the last few decades, and because many mental illnesses are still not detected early, there will always be a group of patients, including those with severe intractable, disruptive, and potentially dangerous behaviour, who need highly structured and secure 24-hour care and those who are not dangerous but need close nursing. These patients and their exhausted caregivers have few resources. Economically depleted and stigmatised, isolated and defranchised, they lack the means to get the basic necessities including food, shelter, medical care, and social support.

In an essay, ‘The Lost Virtues of the Asylum’, the neurologist and writer Oliver Sacks,⁹ who had also worked in a state mental hospital in New York, wrote:

“Asylums offer a life of its own special protection and limitations...for some patients to live through their psychoses and merge from their depths as saner and more stable people...It was not wholesale closure that the state hospitals needed, but fixing: dealing with the overcrowding, the understaffing, the negligence and brutalities... We forgot the benign aspects of asylums, or perhaps we felt that we could no longer afford to pay for them: the spaciousness and sense of community, the place for work and play, and for the gradual learning of social and vocational skills—a safe haven.”

While it is doubtlessly better if patients are enabled to be reintegrated with the community through housing in psychiatric care facilities and sheltered homes in the community, the important, traditional function of the IMH as an asylum should not be overlooked. We speak proudly of the inroads we made in the early detection of mental illness, we showcase innovations in mental health care, we highlight our success in restoring patients to their families, but we are shyly reticent of our role as an asylum—perhaps because that word by now has that derogatory connotation.

But the IMH should be proud too of its willingness to look after these patients and to provide—through all these decades—both a refuge for those who are unable to look after themselves and have no one else who can do that, and a sanctuary where they are sheltered, protected and cared for in a humane way.

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