

By Invitation

Putting the 'asylum' back into mental healthcare

In the treatment and care of people with severe mental illness, the asylum has undergone many changes over the centuries. Covid-19 too has left its mark.



Chong Siow Ann

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Since the Middle Ages, there were asylums which served the sole function of locking up people with severe mental illness. Among the oldest was Bethlem Royal Hospital, the first asylum for the mentally ill in England, founded in the 13th century.

The predominant treatment – if one could call it that – was based on the notion that “madness” was a disease of the physical body which could be cured by purging the individual of “melancholic humours” by inducing repeated bouts of vomiting and diarrhoea, and by bloodletting – often inadvertently killing the patients.

At some point, Bethlem opened its doors to the public who paid an entrance fee to gawp at, or taunt, its deranged inmates. Its colloquial name, “Bedlam”, became a synonym for chaotic madness or mayhem.

It was not just in Bethlem that patients were treated so brutally. In asylums (or “madhouses” as they were also called), it was common that patients were beaten and chained. But towards the end of the 18th century, there emerged the idea that asylums can be made therapeutic by creating within those confining walls, a community with its own orderly routines.

What was known as moral

therapy was widely promulgated – the basic belief was that if mentally ill people were relocated to an asylum in a calm pastoral setting, kept engaged in agriculture and other occupations and where they could live with staff who treat them humanely, they would recover.

The ideal asylum would be – in the words of one of its advocates – “the moral machinery that would return the mad to sanity”.

WOODBIDGE TO IMH

To realise this lofty idea, the physical architecture of these institutions was held to be of cardinal importance. In his essay, *The Lost Virtues Of The Asylum*, neurologist and writer Oliver Sacks, describes state mental hospitals in 19th-century America as “palatial buildings, with high ceilings, lofty windows, and spacious grounds, providing abundant light, space, fresh air, along with exercise, and varied diet”.

There were huge kitchens and laundries, farms and dairies where the patients would work and learn the basic skills of daily life, which, as a consequence of their mental illness, they might have lost or never had acquired before.

I started my training in psychiatry as a young medical officer in the old Woodbridge Hospital – so named because there was an actual wooden bridge across a stream that was on the grounds on which the British had built that sprawling mental hospital in the late 1920s.

Its dormitory-like wards were open and airy, with wide verandas and broad roof overhangs, and a large garden abutted each ward. Patients could mix freely with one

another, and work in vegetable gardens and in the laundry, and there was also tailoring and basketry.

The advent of effective psychotropic medications which enabled most patients to be well enough to be returned to their family and community meant that the role of mental hospitals was no longer solely custodial.

Instead, they became places for the acute treatment of mental illnesses.

But though medication is the mainstay of treatment for most serious mental illnesses, just as important is the restoration of personal functioning, including the ability to attend to one’s needs and connect with others. And this therapeutic function is something that mental hospitals have long built into their structures.

When the old Woodbridge Hospital was torn down and the new Institute of Mental Health (IMH) erected at an adjacent site, its new wards were designed to give some semblance of an ordinary structured day with a sense of community and the prevention of solitude.

The dedicated ward where I see my patients with psychosis has communal spaces for group therapy, social and recreational activities and common dining. There is also a small outdoor garden.

Unlike patients in a general medical or surgical ward where they mostly stay in bed, eat their meals in their rooms and with medication being delivered to their bedside, our patients are encouraged to be up and out of their rooms throughout the day. They attend group therapy, art sessions, play recreational games, watch movies or television, and

take their meals together.

THE PROBLEM OF INFECTION CONTROL

But all that came to an abrupt stop when the pandemic struck.

The measures taken to slow the transmission rate of the virus, to “flatten the curve” and stave off overwhelming the healthcare system were hostile to our usual psychiatric care, and the very design of the wards and what we had been doing, then, seemed anathema to good infection control practices.

Social distancing in our inpatient setting is – to put it lightly – a challenge. Most of our patients are ambulant and those who are acutely psychotic or manic often lack self-awareness and control, and it was hard, if not impossible, to get them put on a mask and comply with safe-distancing measures.

Profoundly depressed patients on the other hand, may be so despondent and lacking in energy that they are indifferent to the consequences or may be so suicidal that alcohol-based hand sanitiser becomes an ingestion hazard.

And there are no means of isolating each patient; we only seclude a patient when there is actual violence or manifest risk of hurting others, and even then, it is for the shortest necessary duration.

With almost 2,000 inpatient beds at IMH and a constant stream of admissions that kept most beds occupied at any one time, it was impossible to keep the virus out of our wards, and it inevitably arrived.

“We had to respond rigorously to that and to keep our patients and

staff safe,” Professor Swapna Verma, chair of the Medical Board at IMH told me. And that meant putting on hold a number of group activities, locking down the wards with movement in and out of the wards severely curtailed, and a ban on visits which were especially hard on our patients who usually stay much longer than those in other hospitals.

It was two years ago that the World Health Organisation declared Covid-19 to be a pandemic. The situation seems better now and with the rolling back of many coronavirus restrictions elsewhere in Singapore, we have also brought back most of those ward activities.

Even as the virus has mutated to the less lethal omicron (at least to the fully vaccinated), it is, more transmissible and still rampant around the world. By no means are we out of this, and even when we do emerge from this, there is always the possibility of another variant, or at another time in the unforeseeable future, another virus, and another pandemic.

A recent article published in the medical journal *Psychosomatics* suggests a possible way to provide institutionalised care for infected patients.

The authors, from the Department of Psychiatry of John Hopkins University, described how they have set up an inpatient psychiatric unit for those with mild Covid-19 symptoms by converting the entire unit into a complete negative pressure space, where the lower air pressure will prevent any potentially contaminated air from flowing out. This allowed patients with asymptomatic Covid-19 infection to freely roam the halls, continue their therapies and spend time in



This man, only known as John, watering plants in the Institute of Mental Health in Buangkok Green. Gardening is one of the rehabilitative activities there. When the pandemic struck, most of the activities were stopped and social distancing posed a challenge, but the situation seems better now. ST FILE PHOTO

common areas.

“We are building for the present and future,” said Professor Verma, as she oversees an initiative to draw up plans for an expanded and enhanced medical psychiatry unit with the facilities and expertise to manage patients with infectious diseases. But beyond the physical infrastructure, there is that pulsing human component.

Addressing that sense of existential vulnerability and omnipresent dread that we all had experienced as professional caregivers in the past two years, she reflected: “We need to be ever mindful of the strain and toll on everyone who are involved in the care of patients. We need to trust and look out for each other, be personally responsible while recognising our interdependence on one another in a culture that everyone is valued and supported.”

In the altered world of the pandemic, we were forced to deliver care in ways that none of us have ever tried and which we know are not optimal nor ideal, and we had to live with those compromises.

We will have to strive to be an “asylum” in its original and noble meaning and function – providing refuge, protection, and a sanctuary for people with serious mental illnesses even in the midst of any contagion. And in a way that we can continue our established practice of helping them to recover from their illness, while keeping them safe and connected in an isolating pandemic.

stopinon@sph.com.sg

• Professor Chong Siow Ann is a senior consultant psychiatrist at the Institute of Mental Health.