COMMENTARY

INVITED SUBMISSION

Objections and Merits: A Commentary on "Improving Long-Term Psychiatric Care: Bring Back the Asylum" by Sisti, Segal, and Emanuel.

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'Asylums', say Dominic Sisti, Andrea Segal, and Ezekiel Emanuel, 'are a necessary but not sufficient component of a reformed spectrum of psychiatric services'; they feel that long-term psychiatric institutions will be beneficial for those 'mental health patients who cannot live alone, cannot care for themselves, or are a danger to themselves and others' (Sisti, Segal, & Emanuel, 2015).

Well, we might wish to start with the obvious objections to this idea. The asylums were often not very nice places. They were "total institutions" (Goffman, 1961), which encouraged stigma. It would be possible for the wrong people to be incarcerated in such a place. If we agreed that a psychotically depressed person should be in the new asylum, when and how would it be determined that he or she should be let out? Would there not be the worry that a recurrence might occur at any time and, therefore, the person should stay incarcerated? Do not these institutions, in any case, breed abusive and infantilizing attitudes? How can you be really person-centred in a total institution? Do people not value their freedom and flourish when their autonomy is respected and how is this possible in an institution, even if it has private rooms? Asylums, in short, may represent a return to the bad old days of prejudice amongst the public and paternalism amongst the professionals.

But are there not, too, some obvious merits to the idea that we need new asylums? Sisti and colleagues (2015) set out such reasons very clearly. In brief, it cannot be said in the USA or in many other countries that deinstitutionalization has been an out-and-out success. People with severe mental health problems can be found on the streets and in the prisons. Even the hostels in which many with chronic mental health problems dwell are often depressingly dingy and situated in the less salubrious neighbourhoods. Public prejudice has not been dissipated by deinstitutionalization; and paternalistic attitudes prevail when risks are identified and issues of safety mean that people with mental illness need to be compulsorily detained.

One rather too glib response to the concerns about asylums is to say that they could all be run in a humane manner. It is, of course, a laudable aspiration. It was the same aspiration that motivated Phillippe Pinel (1745-1826) to call for better care for those in asylums in 1794 and led to the notion of "moral therapy". In 1796, with similarly benevolent intentions, the Quaker William Tuke opened The Retreat in York. The humanitarian and compassionate roots of psychiatric practice are to be found in the writings of these practitioners who encouraged the ideal of asylums as places of humane treatment. And yet, one hundred years later the asylums were often full to bursting point and neither abuse nor scandals were uncommon. The aspirations were difficult to maintain in large, depersonalized environments.

Nonetheless, it is easy to over-state the depressing aspects of the asylums. In many, people were given freedom they would not have had in the community, they were helped to find meaningful occupation, and they were on the whole kept clean and safe. I remember with some fondness studying psychiatry as a student and then as a junior doctor and witnessing the tail end of the asylums. From Mendip Hospital in Somerset, which opened in 1848, you could look down on Wells Cathedral and enjoy the sun setting on an English pastoral scene. The patients working in the workshop seemed very engaged by what they were doing; and they did it well. They produced some change of address cards for a small fee for us when we were moving home. But what was it actually like for them to live there month after month? It closed in 1991. And where did they then live and what did they then do by way of occupation?

Still, an older colleague told me some years later that we should not romanticize the asylums. They were grim institutions. I remember the thickness of the walls at the Littlemore Hospital in Oxford: they were built for containment, if not incarceration. In some ways the anti-psychiatry movement can be seen as a reaction to the asylums. Psychiatry as social control, rather than a medical

art, is an easy story to sell when the evidence of incarceration is so manifest. Getting rid of the shackles is so patently a good thing to do; but so too is getting rid of the walls against which people could be shackled.

We can sway this way and that: the asylums provided humane sanctuary and safety to vulnerable people; the asylums were institutions of control, which were dehumanizing and deeply abusive. Similarly, the community is where we all want to be; but the community is also a lonely and dangerous place for fragile souls. Perhaps, then, the issue is not to do with the building. Let's grant that we do need a 'spectrum of psychiatric services' (Sisti et al., 2015). But if these are to be reformed, it may not be sufficient to say that the reform is structural, let alone in terms of the décor. The reform we need is much more complex.

In the United Kingdom recently, there have been some shocking scandals affecting particular National Health Service (NHS) hospitals and some private care homes. The hospitals were not psychiatric hospitals, although the care homes have involved people with learning disabilities and dementia. Many of the people in the hospitals were elderly. The reports into these abuses have highlighted a number of issues, which have caused a good deal of soul searching (The Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013). For what has been missing, from those who had presumably entered their professions to help people, has seemingly been compassion. The cry has gone up: how do we engender compassion and how do we keep compassion alive? So, whether we have new asylums or community hostels or treatment at home, or even detention of vulnerable people in police stations or prisons, whatever the concrete reality of our institutions, compassion (amongst many other things, such as candour) is an essential ingredient of good care.

This might sound like so much motherhood and apple pie. But luckily there has emerged at the same time an incisive analysis and comment on what is required at a structural level in organizations as well as at a personal level. It is not an exaggeration to say that many of us have been enthused and excited by the notion of "intelligent kindness" as it has been set out by the couple John Ballatt (a manager in the NHS) and Penelope Campling (also a manager, but a psychiatrist and psychotherapist too). They have linked kindness to kinship and emphasized the need for solidarity, between colleagues and between professionals and patients. But the kindness is 'intelligent': we should not suffer fools kindly! We need to see things clearly, to call things as they are and to act decisively.

At the end of their first chapter they say this:

> Kindness, then, is not a soft, sentimental feeling or action that is beside the point in the challenging, clever, technical business of managing and delivering healthcare. It is a binding, creative and problem-solving force that inspires and focuses the imagination and goodwill. It inspires and directs the attention and efforts of people and organisations towards building relationships with patients, recognising their needs and treating them well. Kindness is not a 'nice' side issue in the project of competitive progress. It is the 'glue' of cooperation required for such progress to be of most benefit to most people. (Ballatt & Campling, 2011, p. 16).

So, I am not against the idea of new long-stay wards for vulnerable people with mental health issues. We also need community treatment and, indeed, a variety of ways in which we can see and help people. But whatever the systems and whatever the structures of our care, it must be delivered with intelligent kindness.

References:

Ballatt, J., & Campling, P. (2011). I*ntelligent kindness: Reforming the culture of healthcare*. London: RCPsych Publications.

Goffman, E. (1961). *Asylums: Essays on the social situation of mental patients and other inmates*. Garden City, NY: Anchor Books.

The Mid Staffordshire NHS Foundation Trust Public Inquiry. (2013). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. Retrieved from http://www.midstaffspublicinquiry.com/report

Sisti, D.A., Segal, A.G., & Emanuel, E.J. (2015). Improving long-term psychiatric care: Bring back the asylum. *JAMA*, 313(3): 243-244.

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