Psychiatry at Broadmoor

The Spring Quarterly Meeting was held at Broadmoor Hospital in May 1980 (this issue, page 142). The opening session on 6 May was devoted to various aspects of psychiatry at Broadmoor. The following papers are based on these presentations.

The Development of Broadmoor 1863-1980

By JOHN R. HAMILTON, Consultant Forensic Psychiatrist and Clinical Tutor, Broadmoor Hospital

The history of Broadmoor involves the management of mentally abnormal offenders, or 'criminal lunatics' as they were called, over the last 180 years (Partridge 1953; Walker and McCabe 1973; Allderidge 1977). Before 1800 there were no special facilities for such patients, and they were incarcerated in local prisons where, John Howard wrote, the conditions were 'crowded and offensive because the rooms which were designed for prisoners are occupied by the insane. Where these are not kept separate they disturb and terrify other prisoners. No care is taken of them although it is probable that by medicines and proper regimen some of them might be restored to their senses and usefulness in life'.

On a day in May 1800 James Hadfield, a paranoid schizophrenic, fired a pistol at King George III in Drury Lane Theatre, missing the King's head because he was responding to the audience by bowing. At his trial he offered no defence, telling the court that he wished to be hung, drawn and quartered as God had instructed him to save the world by sacrificing his own life. The Court found him not guilty by reason of insanity and left the authorities with the problem of disposal with this novel verdict.

The answer was Bethlem, which had been a home for the insane for the previous 400 years, managed by the City of London. The supervision at Bethlem was, however, not very strict: indeed Hadfield himself escaped for a short period. Within a month of this trial Parliament hastily passed the first Criminal Lunatics Act under which all those acquitted on the grounds of insanity or insane when arrested could be ordered to be detained in custody 'until His Majesty's pleasure be known'. Thus for the first time criminal lunatics were recognized as a special category and could be detained if necessary for life.

Although secure wards were added to Bethlem, most criminal lunatics did not go there but to prisons or county asylums and, just as today, these mentally disordered patients were unwelcome in prisons and as dangerous patients were unwanted in mental hospitals. Another Select Committee of the House of Commons reported in 1860 that 'To mix criminal lunatics with other patients is a serious evil. It is detrimental to other patients as well as themselves'. The special wings in Bethlem were by now overcrowded and Parliament passed the 1860 Criminal Lunatics Act to make better provision for the care and custody of criminal lunatics and authorized the building of Broadmoor.

Broadmoor's past

The site chosen was a plateau in the Berkshire countryside, as the country air was believed to be beneficial to madness, and the building was designed by a famous architect of the day, Sir Joshua Jebb. The labour was provided by convicts from nearby Woking Prison and the buildings completed within three years.

The first patients to arrive when the institution opened in 1863 were those transferred from local prisons and asylums and from Bethlem, including Daniel McNaughton, and these were all 'Her Majesty's Pleasure' patients found not guilty by reason of insanity or insane on arraignment. From 1877 onwards, when prisons came under Government control, convicts were admitted. Unlike the 'Pleasure' patients, these equivalents of our present-day Section 72 transfers were known as 'Time' patients and were generally free to leave Broadmoor when their prison sentence expired. They could be sent back to prison during the currency of their sentence if certified sane; if still insane at the time they were due for release they were sent to county asylums. It was possible but rare for them to be kept in Broadmoor if too dangerous to leave.

For its first 50 years Broadmoor served the whole of England and Wales. Rampton opened in 1912 for those from the North of England, but soon after it became the State Institution for mental defectives, Moss Side opened for its intended purpose in 1933 when Rampton overflowed. Broadmoor then continued as the only institution for non-defective criminal lunatics, being managed by the Home Office who controlled all admissions and discharges. It is for that historical reason that the nurses' union in Broadmoor was and still is the Prison Officers' Association. By the same token it is possibly understandable that many of the public believe Broadmoor to be a sort of prison hospital. The Hospital has, however, nothing to do with the prison system; all patients are detained under health rather than penal legislation; there are no prison warders, guards or inmates, only doctors, nurses and patients.

In its earlier days, though, Broadmoor was an asylum and the nursing staff were called attendants. The first Superintendent, Dr John Meyer, had a hard time with a large number of escapes in the early years and was himself nearly murdered by a patient who attacked him in the asylum chapel with a stone tied in his handkerchief. Dr Meyer continued with his work, part of which was to record the causes of insanity of his patients; these included Intemperance, Vice, Poverty, Fright, Religious Excitement and Exposure to Hot Climates. Treatments in his day consisted of the usual sedatives and an innovative Rhubarb Treatment. Rhubarb was grown on the hospital farm and each patient was fed an average of 50 lbs a year.

The second Superintendent was Dr William Orange who took over in 1870 having been Deputy Superintendent since Broadmoor opened. He was President of the MPA in 1883 and his portrait hangs in the President's room in the College, painted by Richard Dadd, who was a patient in Broadmoor from 1864 until his death in 1887. William Orange transformed the Institution from its hectic early days into a smoothly running hospital. He was successful in persuading the authorities not to send too many convicts, as they caused so much trouble and kept trying to escape. He also introduced payment for the patients, who until 1874 had as their only reward two glasses of beer a day. Like his predecessor, Dr Orange suffered the customary attack by a patient with a stone in a hanky and so did Dr Nicholson who succeeded him. Dr Nicholson made no changes of importance at Broadmoor; in a public debate about the use of strait-jackets and padded cells, he pointed out that there were none of the latter in Broadmoor and mechanical restraints had not been used for over 20 years. He too became President of the MPA in 1895.

The pattern of Superintendents with a county asylum background was broken by the appointment in 1895 of a prison medical governor, Dr Richard Brown, who introduced an authoritarian regime and released few patients so that numbers grew from about 650 to 840. He was a great believer in seclusion of patients, and in 1896 over 200,000 hours of seclusion were recorded. His prison-type regime was ameliorated by his successor, Dr Baker, who stayed for 10 years, during which time Rampton opened and 200 patients were sent there. Baker was succeeded by Dr Sullivan, who conducted a more relaxed regime with greater opportunities for work and recreation and encouraged patients to take an active part in their own treatment. Sullivan is generally regarded as having been a successful Superintendent who always sought to and succeeded in improving the running of the institution. Dr Foulerton, who followed, generally maintained the *status quo* apart from giving greater encouragement to patients' sports.

In 1938 Dr Stanley Hopwood became Superintendent, and it was he who finally transformed Broadmoor into something more like a proper mental hospital. Among the reforms he introduced were parole (not to be confused with prison parole) with free movement within the walls as the highest privilege. He gradually introduced all the then modern treatments including insulin and ECT and he also appointed psychotherapists to the staff. During his stay the title of Attendant was changed to Nurse and staff were required to pass the nursing examination. During Dr Hopwood's tenure, in 1949, the management of the Institution passed from the Home Office to the Board of Control.

Broadmoor today

Dr Hopwood retired with a CBE in 1952 and was succeeded, for a few years, by Dr Stanley James, until Dr Patrick McGrath, the present Superintendent, assumed the post in 1957; he had been appointed as Broadmoor's first consultant psychiatrist the previous year. In the 24 years he has run the hospital, Dr McGrath has been highly regarded as a most successful Superintendent and been responsible (together with Broadmoor's Medical Advisory Committee) for developing Broadmoor into the thriving modern hospital it is today.

In 1960 the 1959 Mental Health Act came into force, under Section 97 of which the Special Hospitals were constituted. The most important effects on Broadmoor were that the DHSS took over as managers, and for the first time it became possible to admit non-offenders under Part IV of the Act. The relevant section constituting Special Hospitals, which has since been amended by Section 4 of the National Health Service Act 1977, stated that they are for '... patients subject to detention ... who require treatment under conditions of special security on account of their dangerous, violent or criminal propensities'.

From this it will be seen that only detained patients may be admitted. Under Section 98 of the 1959 Act the Special Hospitals are under the direct control and management of the Secretary of State. The DHSS exercises authority through a team of senior administrative and professional officers known as the Special Hospital Office Committee, whose Chairman is the Under-Secretary of DHSS's Mental Health Division. At hospital level Broadmoor is managed by a Hospital Management Team consisting of Medical Superintendent, Divisional Nursing Officer and Hospital Administrator.

The hospital staff

Whilst consultants in Broadmoor have statutory responsibilities as Responsible Medical Officers, they work through multidisciplinary teams. Of paramount importance are the nursing staff, about 500 in number, and we have our own nurse training school. Eight clinical psychologists assist in assessment and treatment. The nine social workers have a difficult job maintaining links with relatives all over the country and help to find hostels for our patients. There are about 50 occupations officers providing perhaps one of the best range of facilities of any psychiatric hospital, and an active education department with three full-time and many

part-time teachers who offer a range of programmes from remedial reading to 'O' Level and Open University.

The medical staff comprises eight full-time consultants, two senior registrars, three medical assistants and four half-time psychotherapists. All doctors are employed under the same terms and conditions of service as in the NHS, though technically we are Civil Servants: we must sign the Official Secrets Act and seek the consent of the DHSS before we speak about Broadmoor in public. Between the consultants there is a total of 80 years service in Broadmoor, which must be a near-unique corps of experience. Links are being forged with the Institute of Psychiatry, and we hope soon to have two new consultants each of whom will have senior lecturer status at the Institute. After some years of reluctance, Broadmoor is steadily developing as a major teaching hospital in forensic psychiatry. Although the hospital has approval for 18 months of the three years' experience required for the MRCPsych, the emphasis is on senior registrar training. Our formal teaching programme includes weekly seminars and an annual residential conference for forensic psychiatrists, criminologists and others.

The patients

Patients come mainly from the Courts under Hospital Order, with a minority transferred from NHS hospitals where they are already detained, or on transfer from prisons whilst serving sentence. The official means of admitting a patient is for a consultant psychiatrist or prison medical officer to make a written application to the DHSS who then consider whether the patient meets admission criteria, which are of course very strict. If the Department is in doubt as to suitability, a Broadmoor consultant may be asked to see the patient and offer an opinion. Alternatively (or in addition) many consultants find it helpful to request a Broadmoor consultant directly to examine the patient. We see this as a service we like to provide, and to advise, if the patient cannot meet the admission criteria, on the best method of management. Incidentally, all these 'outside' consultations are discussed at weekly meetings of consultants and senior registrars as part of our peer review procedure.

The legislation under which patients are admitted include Part IV of the Mental Health Act, Section 26, and such patients are detained under the same conditions as in other hospitals and can be discharged by the consultant, the managers or a Mental Health Review Tribunal. So too can the other group of unrestricted patients who are detained under a SSecttion 60 hospital order. If a restriction order is added the Home Secretary must approve the patient's discharge or transfer. Those transferred from prison under Section 72 normally have a Section 74 order added, but when their sentence expires they are under the same conditions as a patient on a Section 60 alone. The remaining legislation under which patients can be admitted and detained is the Criminal Procedure (Insanity) Act 1964. Here there are two groups of patients—those unfit to plead and those found not guilty by reason of insanity. In the former, the Secretary of State directs the patient's admission and it is possible to have the patient, when fit, brought back to Court to stand trial. Those found under the Special Verdict 'McNaughton mad' as they are prettily called, are likewise directed to Broadmoor by the Secretary of State and like the 'unfit to plead' detained under a restriction order.

The number of applications to the Special Hospitals was 381 in 1979, of which about 60 per cent were accepted. Of some 200 annual admissions to the Special Hospitals, Broadmoor takes about 80, Rampton 80 and Moss Side 40. Of these about 14 per cent are readmissions. What is not always apparent is that the same number are discharged as are admitted, otherwise we would have to build a new Special Hospital every couple of years. There is a waiting list for admissions—not from the Courts, as we must take them within 28 days, but for those on Section 26 in other hospitals or Section 72 in prisons.

Broadmoor currently has 720 patients, of whom 120 are women. Of the 720 a score are below the age of 21 and the same number over 65. The mean age on admission to a Special Hospital for a patient with mental illness is 32 and with psychopathic disorder, 24. As to the offences of those admitted, more than a quarter have committed homicide, with attempted murder and other major violence forming the single largest group. Most of the remainder comprise serious sexual offences and arson. Broadmoor does not admit patients with mental subnormality. Seventy-four per cent of the patients have a Mental Health Act classification of mental illness and 26 per cent psychopathic disorder. Eighty per cent of the patients are on restriction orders.

It is possible for patients to leave by way of a Mental Health Review Tribunal. Unrestricted patients can be discharged thus; restricted patients may have a hearing, after which the Home Secretary may accept or reject the Tribunal's advice. Nowadays at a large number of our Tribunals there are barristers representing the patients. It is also proposed to double the number of times patients can apply for a Tribunal and to institute automatic Tribunals for those who do not apply; obviously this will have serious repercussions on our work load.

Usually patients leave after their consultant recommends to the Home Office transfer or discharge, and rarely are there problems in securing agreement; the relationship between Broadmoor consultants and the Home Office is, I think, very good. In general, patients with mental illness, most of whom are schizophrenic, are transferred to NHS hospitals, whilst those with psychopathic disorder are conditionally discharged to a hostel to be supervised by a probation officer and a consultant psychiatrist. We often do this supervision ourselves. The formal way to obtain a bed for transfer is to ask the DHSS, who in turn ask the Region, who ask the Area, who may then ask the District, who pass it on to the Sector. We find it quicker and more profitable to identify and ask the relevant consultant. These has been

much publicity lately of Susanne Dell's work (1980) demonstrating the large numbers of Special Hospital patients awaiting transfer to NHS hospitals: that the number of such patients is growing and the waiting period longer. In Broadmoor at the last count we had 51 patients who should no longer be there.

Broadmoor's future

These are some of the problems facing us today, as if we do not have enough in simply considering patients for admission, treating them and assessing them for discharge. As to the future, any new legislation dealing with consent to treatment for detained patients might seriously affect us, but Broadmoor has never asked to be treated differently from other hospitals except on grounds of security. We shall have problems over the next few years when several of our most senior consultants retire, including Dr McGrath, and they will be difficult to replace. We shall deal with all the difficulties inherent in replacing an ancient monument with a purpose-built modern hospital with many fewer beds but which will relieve our terrible overcrowding, commented on by the Estimates Committee of the House of Commons in 1968, the Hospital Advisory Service in 1974 and the Butler Committee in 1975. Lastly, my personal view is that Broadmoor has a public relations problem caused by the 'can't win' phenomenon. We either let them out too soon or keep them in too long, or we let the wrong ones out, and so on. I believe we must develop an effective publicity machine to show the public, and indeed the profession, what our problems are. We invite psychiatrists everywhere to help us to solve them.

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Broadmoor's Relationship with NHS Psychiatric Hospitals

By K. LOUCAS, Consultant Psychiatrist, Broadmoor Hospital

Just after the First World War, in 1919, and before the more recent legislation that has shaped the philosophy of this hospital, one Ronald True was sentenced to death for the killing of a young woman from Fulham. The records described her as 'handsome'. (She may have been a prostitute.) The public was outraged when the Home Secretary of the day, on receiving the statutory Medical Certificates, ordered a reprieve and Ronald True came to Broadmoor Hospital. Here he passed his time writing doggerel and lyrics to old and popular tunes. One of these, sung to the tune of 'John Brown's Body' goes:

'There is a piace in Berkshire
Where the lunatics reside
It's called the British Bastille
And it's famous far and wide.'

As you made your approach up the hill and perhaps tried to gain entry, you will no doubt have been impressed by the architecture: Prison Baroque. Inside, closed doors and jingling keys are constant reminders that it is a different world. But it is not a prison. As Dr Hamilton has explained, it has never been a prison. For all its high walls, locked doors and limited freedom, it is and always has been a hospital; and since 1948 part of that same National Health Service which we all enjoy. Different it is, special it certainly is.

One of the most important British contributions to psychiatry has been the 1959 Mental Health Act. It changed the relationship between the alienists and the public. With the help of the boom in psycho-pharmacology it changed the unacceptable face of psychiatry. It threw away baby, bath water and the bath. Turnover of patients and discharge became the name of the game. Straight line graphs gave a prediction of zero-need for Asylums. Plans for closing the big institutions gave rise to the inevitable planning blight. Everybody went into the Community.

There is much to be done: out-patient clinics, day hospital, domiciliary visits, lectures, meetings and so on. Last week I was asked to see a patient at one such erstwhile Lunatic Asylum—come Mental Hospital, now 'Therapeutic Community'. Having enquired after the doctor who had requested the consultation, I learned that he came on Wednesday mornings—not to the ward but to the hospital. His task, clearly, is an impossible one with 200 in-patients and all the associated organizational responsibilities.

The *Guardian* headlines in August last year (not front page but prominent enough) carried a caption that read 'Open door—Open mind'. The article told how the scandal of delays in getting proper treatment (in the Community) had been solved. Lewisham had been provided with a Self-referral Walk-in Clinic. All part of this most worthy, highly laudable service to the Community. Community care in the