'Psychopaths' in Special Hospitals

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The continued existence of 'psychopathic disorder' in the Mental Health Act of 1983 ensures that well into the next century individuals thus categorized will be detained in Special Hospitals and elsewhere. In this paper I want to consider the problem of 'psychopaths' in the Special Hospitals, as I see them, both for the patients and the institutions, and I will pay special attention to the way such patients are detained. More specifically, I will argue that greater use should be made of treatment orders during the course of a prison sentence, rather than at the time of conviction. In other words, let there be more use of Section 72 of the 1959 Act (to become Section 47 of the new Act), as opposed to Sections 60 and 60(65), which in the new Act become Sections 37 and 41 respectively. At the end of 1982 only seven out of about 150 'psychopathic disorder' patients in Broadmoor were detained under Section 72. The great majority were held on Section 60(65).

Two main reasons underlie this preference. Firstly, when someone has committed a serious offence that would attract a long sentence he can be given the opportunity for treatment at some stage during the period of that sentence. This allows the patient (and everybody else) to perceive the clear distinction between the penal and therapeutic aspects of the detention. Instead of going straight to, say, Broadmoor Hospital on what is effectively an indeterminate sentence, he can go to prison and later seek or be offered treatment during the course of what will more usually be a determinate sentence.

The other main reason for the preference is that if the patient goes from prison to Special Hospital on a Section 72, and is found unwilling or unable to use the facilities of the hospital, he can return to prison and somebody else can take his valuable hospital place. If, on the other hand, the patient benefits from treatment, he can be returned to prison when it is thought that no further help might be obtained, and that no deterioration would take place as a result of such a move. In some circumstances return to prison would be inappropriate, but at least the provision to do so is there. The great advantage of Section 72 over Section 60 or Section 60(65) is the flexibility it affords.

It is a commonplace in the Special Hospitals that many people detained under the category 'psychopathic disorder' bitterly resent the stigma of being in hospital and are glad, in some cases, to return to prison. For this reason it is very useful to have this facility for movement in both directions between prison and the Special Hospitals. If used more extensively, Section 72 could provide for the more rapid turnover of patients that Special Hospitals greatly need and seek to provide. This would boost both staff and patient morale. Instead of becoming essentially long-stay institutions, with the mean duration of stay of over six years, a substantial number of personality-disordered individuals could come into Special Hospitals for shorter periods of time, receive treatment, and then depart to make way for others. Those coming in would know their stay and prospects of treatment to be contingent on meaningful co-operation, and the dilatory, disenchanted and disruptive could be relieved of their places, and returned to prison. This is not, of course, to say that difficult patients should be, *per se,* returned, but simply that when treatment has not been possible, or has failed, it should be possible to act on this fact in a positive way.

Psychopathic disorder: legal and clinical aspects

The Butler Committee considered at length the various problems that the 'psychopathic disorder' gives rise to. They noted the general lack of consensus among experts in the field about what the term actually denotes, and cited Sir Aubrey Lewis' familiar criticism of the many terms used synonymously over the years: 'these and other semantic variations on a dubious theme have been bandied about by psychiatrists and lawyers in a prodigious output of repetitious articles'.

In their report the Committee listed the many arguments put to them favouring the deletion of the term from mental health legislation. Firstly, psychiatrists disagree about the term and its diagnosis in particular cases. Secondly, the term was described as logically defective, inferring mental disorder from antisocial behaviour, while explaining the latter by the former. A third criticism of the concept was that moral explanations of behaviour were being ousted by medico-scientific ones. Another criticism of the term was that it had proved stigmatic, harmful and indelible, and that it made those so labelled more difficult to handle.

Nevertheless, despite these and other criticisms of the concept and its use, the Committee was plainly in favour of the continued interest in such patients by the psychiatric profession, and proposed the development of training units within the penal system for 'the training and treatment of dangerous antisocial psychopaths on a voluntary basis in special units', emphasizing the need for built-in research at the outset. They did not recommend dropping the term from the Act.

The Mental Health Act 1983 defines 'psychopathic disorder' as a 'persistent disorder or disability of mind (whether or not including significant impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct' on the part of the person concerned. The old tag of 'and requires or is susceptible to treatment' has gone, but is replaced elsewhere in the new Act by 'such

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treatment is likely to alleviate or prevent a deterioration of, his condition'. Neither of these tests of treatability can be regarded as particularly stringent. It is also difficult to see how in any material sense they differ from each other.

The new Act will confer a number of benefits to psychiatric patients generally, but clearly the position of the patients with 'psychopathic disorder' will alter little. However, the Butler Committee's recommendation of the interim hospital order has now surfaced in the new Act (Section 38), and this may help hospitals to decide on who should or should not be given a hospital order.

Section 38 will allow a court to send a convicted man to hospital for 12 weeks, and thereafter for further periods of 28 days to a maximum of 6 months, to determine his suitability for a hospital order. The main problem with this proposal is that it simply postpones the day at which the hospital order is made, at which time the old problems referred to return. Six months may well be insufficient time to assess the likelihood of benefit from treatment in certain people. Or, to put it slightly differently, six months may not be long enough to decide who will benefit from a hospital order as opposed to being given a custodial sentence. This qualification is made because the decision to recommend a hospital order must take into account more than just the anticipation of a 'treatment', but all the implications of the environment in which the treatment will be offered. Unfortunately, the stakes are high in forensic psychiatry, and the error, for example, of bringing a particular man into Broadmoor Hospital, diagnosed as suffering from 'psychopathic disorder', who is undoubtedly dangerous, and eventually shown to be totally unresponsive to treatment, is a serious one.

The price of treatment failure

Patients admitted to Special Hospitals as suffering from 'psychopathic disorder' are extremely diverse, but several types of treatment failure soon become familiar.

A man commits a number of sadistic, homosexual, paedophile offences and ultimately kills one of his victims. He goes to a Special Hospital where it emerges that he is completely immutable, despite the extensive treatment opportunities that are made available for him. After 10 years he admits unchanged sexual attitudes. While in the institution he presents no management problem and gets his parole within it and grows older. After 20 years he is older and perhaps wiser, but his sexual aspirations and attitudes are essentially the same, although his libido is somewhat lessened. He is grossly institutionalized.

The tragedy of this man is, in fact, even greater than the personal issues of his institutionalization, poor treatment outcome, and the effective indeterminancy of his sentence. Another victim of his inappropriate hospital order has been the hospital itself. Apart from the financial cost of such failure (approaching £20,000 per annum at current prices), the impact on staff and patients of someone who is unchanged and unchangeable, and who is going nowhere, is quite simply appalling. The Special Hospital in this case fulfils no more than a custodial role, and the hospital order is simply an indeterminate sentence.

Another story, not uncommon in Special Hospitals, although happily less common than 10 years ago, is that of the man who has from early on been delinquent and involved in minor violence. In adulthood his criminal and assaultive activity escalates and, following yet another assault of one kind or another, he is brought into a Special Hospital. At an early stage he proves disruptive, resentful at being in a hospital for mental disorder, and sets out to cause trouble. However, because he is on Section 60(65) he is stuck with the hospital and it is stuck with him. Such situations can create a very unpleasant atmosphere and nursing attitudes can easily harden in the face of the open hostility and violence that often result. Such a patient always finds himself in conflict with those who he now calls 'screws'. The time and energy the nurses would like to use on the more needy and willing patients is expended in maintaining safety and security because of the one dissatisfied customer. It is not hard to imagine the impact on an institution that half a dozen or more of these individuals could convey to the hospital.

A third variant is the more dependent, inadequate type of man. He has had few lasting relationships and is both fearful of close contact and yet hungry for it. His insecurity causes him to be unreasonable and sometimes violent in his relationships. In the Special Hospital he behaves impeccably, making every attempt to oblige and co-operate in treatment, and is well liked and trusted by staff. In hospital he is safe, being completely supported by the predictable dependability of the institution. Yet the circumstances in which he reacts violently are unchanged. He too remains unchanged, apart from in age, and he becomes institutionalized. In his case the hospital has served hostel function.

So far I have tried to show some of the ways valuable hospital time and resources can be wasted by attempting to treat the untreatable. This is not to say, of course, that all those with personality disorders are untreatable; nor is it argued here for one moment that they should never come to Special Hospitals. The point at issue is that such individuals, the prisons and the Special Hospitals, would all be better served if these patients had come to hospital after conviction, simply because of the flexibility of movement afforded by the Section 72, compared with the Section 60 or Section 60(65).

The use of the latter for bringing the personality-disordered into the Special Hospitals suggests several bold and ill-founded assumptions. Those making such a recommendation are presumably anticipating that the patient-to-be is motivated to get help, will comply with treatment and that such treatment is going to help him. But surely such assessments can hardly be made in a reliable sense when somebody faces a court hearing and possibly a hefty sentence?

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What does such a person know of the implications of 'treatment' or of the setting and circumstances in which this will take place? Even with the most assiduous investigation and preparation, neither the doctor making the recommendation nor the patient can realistically predict the outcome several years hence.

It is sometimes hard to reject the suspicion that some patients are recommended for Special Hospitals more because they are considered dangerous, unusual and in need of containment than because of their supposed responsiveness to treatment, their motivation to receive it or their probable compliance with it, each of which phenomenon is in any case an elusive thing. Such a recommendation is effectively an indeterminate sentence. The duration of the patient's stay will often correlate inversely with the treatment outcome. This is surely not cost effective? At other times the view is perhaps taken that compliance and motivation are relatively unimportant, and that 'treatment' is something that can be conferred passively, more or less. Other psychiatrists may take the view that one has to admit psychopaths and 'be prepared to lay them down, like a good wine, for one's old age'.

Many patients with 'psychopathic disorder' are admitted by doctors who anticipate the eventual use of some sort of psychotherapeutic endeavour in their treatment. But slender resources of this kind are greatly stretched, and it is important that treatment is not offered with other than the most scrupulous care. It is not sufficient to be able to identify psychopathology, to formulate in dynamic terms the meaning of repetitive deviant behaviour. One must also fulfil other criteria. I believe that paramount among these is the ability to establish a degree of motivation in the patient, and acknowledgement by him that all is not well, and a willingness to undertake some work in that direction. These must surely be the very least for which one could hope. I would personally welcome a widespread discussion within the psychiatric profession on the extent to which criteria for out-patient psychotherapy are irrelevant for those in whom psychotherapy is anticipated in the Special Hospitals. Those involved in out-patient psychotherapy are usually particularly assiduous in their selection criteria. They are mindful of the need not to cause harm, of the need to offer help to those who are likely to benefit, and are alert to the shortcomings of the treatment modality itself. Furthermore, such assessments are usually undertaken by the doctor who anticipates giving the treatment himself. Thus, the selection is made in circumstances likely to 'concentrate the mind', and in these circumstances one would be very careful to avoid taking those for whom treatment would be likely to be unhelpful. The price of making an inappropriate selection for admission on the basis of anticipating response to psychotherapy is a particularly grave mistake when the patient comes to a Special Hospital.

The main point I have sought to make is that there are some advantages of a practical and tangible kind in admitting those with 'psychopathic disorder' to Special Hospitals after they have been sentenced, rather than at the time of the sentencing. As regards the submission of evidence in court it seems reasonable to express the sorts of doubts and uncertainty alluded to already here, and to recommend in favour of reconsideration of a medical disposal at a later stage, in the event of a finding of guilt and a custodial sentence.

Certain caveats must be observed. Firstly, having identified someone on remand who might be suitable for admission later it is necessary to follow him up, and to make the necessary reappraisal of the patient and his circumstances when he is now serving the sentence. This requires administrative efficiency and good will from various colleagues. The patient, of course, if he has only received a short sentence, may now vigorously reject the offer of a bed in a Special Hospital, which will in any case be revealing about his motivation. Finding himself on a two-year sentence, motivation and compliance, for any sort of treatment, might suddenly evaporate.

Secondly, an already established hazard and injustice sometimes consequent upon the use of Section 72 is the risk of 'double track' sentencing. Thus the man who gets four years for, say, a sexual offence, and who is whisked away to a Special Hospital a short time before his earliest date of release has been dealt a serious injustice. His treatment compliance and motivation are unlikely to be of the highest calibre and such a move is clinically unsound in the extreme except in the cases where newly arising psychotic disorder is found.

Thirdly, the patient should have a clear understanding of the circumstances to which he is going, of the difficulties implicit at times in psychotherapeutic or other work involving personal change, and of the responsibilities he will have to undertake. He will need to appreciate that his failure to make use of the offer of treatment within an agreed time limit would bring about his return to prison. (Needless to say such a statement should not be an empty one; the possibility to transfer patients in each direction with the minimum of delay would not only be desirable but very necessary.)

Conclusions

There are a number of advantages of providing treatment to those labelled 'psychopathic disorder' under Section 72 compared to Sections 60 and 60(65):

1. The problems of wrongly assessing treatment compliance, motivation and responsiveness are obviated, or at least much reduced.
2. More patients could be treated and ultimately returned to prison if this seemed appropriate or desirable. Thus, instead of having one patient for 10 years, one might treat 5 for 2 years each. Beds would not be blocked by manifest treatment failures or non-responders.
3. The Special Hospitals would benefit greatly from the increased patient turnover, both in terms of (a) financial

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cost effectiveness, and (b) the value to morale of staff and patients of seeing this sort of turnover. Compulsory detention, as an end in itself, could be greatly reduced, which is the position that obtains for a number of patients after a few years in which treatment has been to no avail.

4. The prisons would benefit, having access to more beds more quickly. The beds currently blocked by treatment failure would be liberated more readily. Both prisons and Special Hospitals would benefit from an improved dialogue between them, with easier two-way movement of patients.
5. There would be an improvement of the ethos of Special Hospitals, away from the sometimes excessive emphasis on security and safety. These concerns are often initiated by the activities of a few embittered, untreatable patients with personality disorder who see no way out of hospital, and who have little to lose by disruptive behaviour, or worse.
6. The increased patient turnover would have obvious and beneficial effects to the research into aspects of treatment, nosology and aetiology of those with personality disorders. Without such research, especially into the various aspects of management, the future of the Special Hospitals in this respect must be considered in jeopardy.

The views expressed are solely those of the author and do not necessarily represent those of Broadmoor Hospital, the Institute of Psychiatry or the DHSS.

Who Cares for the Adult Brain Damaged?

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There is increasing interest in services for younger brain damaged persons (acquired in adult life as a result of trauma or illness). However, there is uncertainty about the type of service needed and to whom the medical responsibility belongs.

My own interest began in 1981 when I took over consultant responsibility for the Hamble Unit. This 28-bed unit opened at Knowle Hospital (Adult Mental Illness) in 1973 and serves the Southampton Psychiatric Health District. Patients had previously been placed in long-stay and psychogeriatric wards.

Over the last decade patients have been selected on the criteria of becoming brain damaged in adult life, requiring a high degree of both physical and psychiatric nursing and frequently having behavioural problems. Previously it was considered that they were not receiving optimal care and, furthermore, they were disruptive on other wards. The philosophy of Hamble Unit has always been to promote the highest possible quality of life in these grossly handicapped patients, and also to create and maintain as many links as possible with their families and the community. Initially the Unit was seen as a final placement, including terminal care. However, this meant that patients were denied admission in acute phases of behavioural disturbance after head injury, for example, and in recent years we have felt that the team's skills can be appropriate to selected patients who have considerable potential for recovery and rehabilitation. Furthermore, we have found it feasible to mix patient types and this is important for staff satisfaction.

Preliminary analysis of nearly a decade of experience in the unit shows that the following categories of patients have problems where nursing in a special brain damage unit is appropriate at some stage in their illnesses:

(1) Late stages of progressive dementing illnesses usually associated with physical frailness: e.g. Huntington's Chorea, Alzheimer's Disease, Disseminated Sclerosis with cerebral involvement; (2) Non-progressive (or not necessarily progressive) brain damage: e.g. alcoholic dementias, brain damage due to epilepsy, frontal lobe type syndromes after non-communicating hydrocephalus and cerebrocascular accidents; (3) Traumatic brain damage: (i) early, with behavioural problems and (ii) late—severely cognitively impaired patients, invariably with severe physical handicaps and communication disorder.

The unit has never attempted to be a 'sick ward to the hospital'. Patients in some of the above categories may at some stage be nursed on other wards when their awareness and cognitive functions are less impaired. Generally we find patients with progressive illness, particularly with involuntary movements, are more comfortable and less embarrassed on the unit.

It is difficult to gain an impression of the size of the problem, either on a national or local level. Certainly there are few specialist units. Occasional patients, after head injury with severe behavioural problems, are totally misplaced and can create exceptional havoc in a medical setting. Some Health Authorities are prepared to finance contract beds at specialist units (e.g. the Kemsley Unit for brain injury behaviour disorders at St Andrew's Hospital, Northampton)—others are not. National figures are not very helpful. The last in-patient census in mental hospitals was in 1971. An outline estimate from this shows that there were up to 4,840 patients with the characteristics of 'dementia before the senium' in mental illness beds in England and Wales,

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