Broadmoor Hospital – a unique facility

From the year of Broadmoor's sesquicentenary **Tony Black** presents a professional memoir, looking back to its centenary in 1963

The profession of clinical psychology was effectively brought about by the creation of the NHS in 1948, which, by the time of Broadmoor's centenary in 1963, comprised over three hundred posts. Yet mental hospitals, as they were then known, had only been gradually following the example of the teaching hospitals and setting up posts of their own; Broadmoor, in Berkshire, followed the trend in 1959 by appointing me.

To see how it was by 1963 needs explanation of how I had decided to shape the new service for this challenging and intriguing place when appointed those few years earlier.

In 1959 I was interviewed in the daunting Savile Row offices of the then Ministry of Health. Asked if I had any questions, I caused surprise by saying 'Yes'. I asked if money would be available to set up a lab. Don Walton, who trained me at Rainhill Hospital, Liverpool, on the probationer in-service system, had urged the need for lab facilities in the expanding role clinical psychologists were developing and John Tong, at the sister special hospital of Rampton, showed me his own lab on my visit there. The two-man appointment board asked how much, and I said: 'About five hundred pounds' (a cheeky ask, 54 years ago). They smiled and thought they could manage that and, indeed, Dr McGrath, the new medical superintendent, had emphasised his hopes for research at Broadmoor – an invaluable 'quote' subsequently.

Broadmoor life

In 1959 Broadmoor didn't seem too different from other mental hospitals of those days but peripheral security was clearly tighter, the wall more impenetrable and checking of everything more meticulous. Separate keys operated for the male and female wings, graded from M1 or F1 for the ward staff up to M5 for the physician superintendent. There was a further 'top lock' key for all ward doors when they were locked at night as well as round the clock on the two ward blocks housing the most disturbed patients. My key was M4 and I had a top lock key, but I had to phone in advance if I was visiting the most disturbed wards (the 'back blocks') and arrange an escort to accompany me when seeing a patient in the female wing.

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At about 850 patients at that time (in a hospital built for 500) and some 40 acres within the walls there was considerable scope for a varied life for this long-stay population. This included a wide range of workshops, kitchen gardens, a chapel choir, a choral group, a drama group (the 'Broadhumoorists'), recreational activities on each of the ward blocks, including table tennis and snooker tables, and a television in each ward.

Groups of half a dozen escorted parole patients worked on the grounds outside the walls, though the former hospital farm was by then privately run. Musical instruments, hobbies and gardening were all encouraged, whilst a large sports field enabled football, cricket and athletics to take place. The whitewashed inside of the perimeter wall was claimed to be the largest sight-screen in the country, whilst all matches were played at home! There were bowling greens on the terraces of both male and female wings whilst the women had the addition of a croquet lawn. The finals of the sporting competitions, as with the parole patients' dances in the central hall, were social functions that the hospitals' 'officers' were expected to attend with their spouses, the superintendent's or chaplain's wife usually presenting the prizes. The kitchens were also a patients' workplace and provided impressive refreshments for these occasions.

Admissions

Arriving in 1959 afforded a year's experience of the pre-war legislation because the radical changes of the 1959 Mental Health Act weren't implemented until November 1960. The new Act did not affect the way patients were admitted to Broadmoor as it did elsewhere (where admission on medical grounds, rather than a magistrate's authority, was a revolutionary change). The majority of patients still came via the courts, with a number transferred from prison. It affected the type of admission, however, which doubled the annual admission rate in the space of a few years, from 70 to

further reading

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Broadmoor Gatehouse

140 men and from some 10 to 20 women. This was catastrophic for a building already over full. Some day-room facilities had to be given over for dormitories, and beds were sometimes set up in corridors. This increase at an already overcrowded hospital was partly due to the new Act's inclusion of 'Psychopathic Disorder', for the first time as one of the its four categories of Mental Disorder, but partly also to the category of 'Mental Illness' replacing the longstanding criteria of insanity defined by the M'Naghten Rules. The latter restricted admission eligibility to those who were too insane to 'instruct counsel, understand evidence, challenge witnesses, understand the nature of their actions, etc.'. 'Mental illness' was intentionally an altogether looser concept. The range and number of admissible mental disorders thus greatly increased the admission rate. Dangerousness was still the crucial extra criterion applied, with the new Act allowing those who had committed lesser crimes (e.g. petty theft) to be treated in local psychiatric hospitals. Among other factors in the new Act increasing the workload was the introduction of Mental Health Review Tribunals to which patients could appeal against their continued hospitalisation

Assessment

The strategy for a psychological service, I decided, must include setting an admission baseline from which to assess change and ultimately fitness for discharge or transfer, the vital special hospitals' question and one emphasised to me by John Tong at Rampton. I used the routine test of those days (WAIS) to assess the impairment of those abilities which typified certain mental disorders; a test of perceptuo-motor impulsiveness (the Porteus Mazes) to reflect this facet of psychopathy; and a widely used questionnaire (MMPI) with norms for various psychiatric conditions and personality traits linked with impulsivity and psychopathy.

This assessment of all admissions would also be used on potential discharges to show differences that would hopefully confirm improvement. Ultimately longitudinal assessments would accrue, and years later I managed to complete a follow-up study of a five-year cohort of male discharges.

These early tests might nowadays be thought dubious but they were standard usage then in augmenting psychiatric opinions, one of the reasons for clinical psychologists having been introduced to the NHS. Data logging for research at Broadmoor also needed to look at both psychiatric diagnosis and offence category, thus doubling the research load. So a treatment role had to wait for both data to accrue and the department to acquire more people to undertake it.

A male staff nurse was attached to me as both escort and someone who could keep records and carry out routine testing. As a former staff sergeant in the REME he was well drilled in military routines and so an ideal person to train for the job. Between us we managed to keep up with the doubling of the admission rate in the 1960s. There was no other clerical back-up at that time except in the medical office where the typists struggled to fit in my reports to their schedule.

There were naturally also specific referrals for psychological investigation, chiefly from the two consultants, leading to use of a wide range of other psychological tests of that era whilst another arm of our information gathering was a survey of the entire male wing of the hospital (the female wing would have to come later). Small groups at a time were given the Raven's Matrices, the Mill Hill Vocabulary and the Maudsley Personality Inventory. This proved helpful for subsequent investigations and showed a generally high level of ability in the patient population, to the surprise of many and despite the impairment of the more acutely disturbed patients (the 'Mental Subnormality' and 'Severe Subnormality' categories of the 1959 Act went to Rampton or Moss Side Hospitals, their role in those days.) This work also helped to make the case for expanding the workshops and recruiting more occupations officers, whilst an education officer was recruited and a 'school' created. Furthermore it helped our social worker who had to arrange a job and a place to live before a patient's discharge could be approved. Vocational interest and aptitude tests were used for this.

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Research

What of the lab then? Well, it was built and it gradually acquired equipment. A student who had built one for John Tong at Rampton built a device for presenting a sequence of lights of varying complexity and at increasing speeds for measuring change of response under stress (revealing over-reactors and under-reactors), a method devised for pilot selection in the war. The student had formerly been a telephone engineer and made use of telephone relay equipment from the government surplus stores of those days. Dr McGrath called this the 'demented pianola', which he took delight in bringing VIP visitors to see. In later years, the lab was increasingly developed, including the addition

Patient in workshop – operating a steampress

of a polygraph. This was not used as a lie detector but to compare autonomic responses to various sensitive stimuli related to patient's offences, compared with neutral ones, and under controlled conditions in the lab (contrary to criticisms from press and patients' rights groups who thought patients were being encouraged to indulge their deviant fantasies).

Case conferences and treatment

A weekly admission case conference took place in the superintendent's grand panelled office with its array of Richard Dadd's paintings. In 1959 there were only two consultant psychiatrists, the medical superintendent and a part-timer shared with St George's. The case was presented by one of the three senior registrars and a staff nurse who reported the patient's condition since admission. The social worker and I also presented our findings whilst also in attendance were an SHMO (senior hospital medical officer) who was also deputy superintendent, the CMN (chief male nurse, matron for the female wing), and the chaplain –a prominent figure in hospital life in those days.

The outcome of the case conference would be a diagnosis, treatment plan and a decision as to which ward block the patient would be sent. The most disturbed and difficult to manage would go to Block 6, otherwise the majority to Block 4. With my heavy involvement in assessing the parameters of the population and the condition of each new patient, there was little scope for an involvement in treatment, although my suggestions for what the nascent psychological therapies could provide were often invited with the somewhat taunting question: What has conditioning got to offer, Tony?

Secluded patient's room

Psychiatric treatments in those times mainly comprised one or other of the plethora of pharmacological drugs being developed; or electro-convulsive therapy. This latter continued for many years, not only for depression but also in many cases of schizophrenia, although anaesthetics were used to reduce the distressing and potentially damaging convulsions that would otherwise ensue. Surgical leucotomies, still being done weekly when I left Rainhill, were taboo with Dr McGrath who maintained we had too many patients who had been brain damaged therapeutically anyway! Insulin coma therapy was still being done but was discontinued not long after.

Centenary and beyond

This, then, was the hospital, its work and my role at the time of the centenary in 1963.

When the centenary came, Broadmoor arranged the usual celebrations including the hosting of several conferences of professional bodies. One of these was for the BPS's Committee of Professional Psychologists, forerunner of the professional Divisions, where I presented some of our early findings. I did the same at the eleventh hour to replace an indisposed speaker for a meeting of the Royal Medico-Psychological Association, forerunner of the Royal College of Psychiatrists.

At this meeting I presented some of the findings from our admission assessments that demonstrated differences between patient groups defined both by diagnosis and by offence. Some were to be expected but the unexpected ones caused some surprise. The main surprise was that a substantial group of the most 'severe' offenders (i.e. the homicides) showed predominantly unimpaired, symptom-free profiles. They also showed high levels of defensiveness. Only later in the 1960s when Ron Blackburn joined the department, did the explanation begin to emerge. He analysed the admission data in more detail and derived a number of distinct patterns, one of which was clearly the same as a group described at that time in the USA by Edwin Megargee as 'over-controlled'. Thus a term that has passed into common use began its UK life at Broadmoor.

Parole patient's room

More research followed and staff additions by the 1970s went on to develop treatments of that era such as social skills training and, later still, anger control. I hope this gives the lie to the often voiced view that Broadmoor was an academic and professional backwater.

That Broadmoor has patients, not prisoners, with treatment and an active and varied life within its walls, and that pioneering professional work goes on there, often surprises the world at large, who believes Broadmoor to be a bear pit of hopeless cases. Repeated publicity fails to change this view. The public seems to have a need for an 'out of sight, out of mind' attitude. Of course, there have always been wards where there are highly disturbed patients who spend protracted spells in seclusion. But the majority would settle and improve with the medication of those days, plus good nursing, occupational and recreational facilities. The psychotherapies were yet to come, although the two consultants did what they could. Until the system was satisfied that they were no longer likely to be a public danger, however, patients stayed there.

Calls for Broadmoor's closure didn't occur in those days when psychiatric hospitals were opening their doors and depending on the backstop of Broadmoor to sustain this. Nowadays such calls are frequent, but this unique facility seems vital in order to allow the rest of the system to work, although the regional secure unit system now helps to spread the load.

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