

## A PSYCHOPATHIC UNIT AND ITS COMMUNITY SETTING\*

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The English Mental Health Act due to come into operation in 1960 makes legal provision for the compulsory psychiatric treatment of the psychopathic patient. It marks one stage in the treatment of "those community offenders of whatever intelligence whose offences are part of a nonpsychotic psychiatric syndrome derived from longstanding behavioural patterns" (1). As Sir David Henderson (2) has said, the psychiatric abnormality centres on "the emotional instability, explosiveness and in particular the egocentricity and emotional immaturity which is common to all." It is clear from texts on mental deficiency such as those by Tredgold (3), Shrubshall (4), the Clarkes (5), and recent research (6) that many of these patients have been certified and treated as defective on the grounds of emotional retardation, but of recent years there has been a movement away from certification. Yet few psychopaths are anxious or willing for treatment. An attempt to meet this dilemma has been made in the central Sheffield region.

The building of Balderton Hospital was started by Nottinghamshire County Council in 1931, it being opened by the Sheffield Region in 1957. During the winter of 1958 a treatment plan for psychopathic males on probation was started, based on the results of research (6), in an unlocked, open, geographically independent ward of thirty beds. This paper describes the use of this unit and the services connected with it by the different members of the community that are involved. Monthly meetings are held in the University of Nottingham, chaired by one of us (P.P.) to discuss mutual problems.

The legal position, reports A.C., is based on the 1948 Criminal Justice Act and the 1952 Magistrates Court Act. Section 14 of the latter provides magistrates with power to adjourn a case after conviction and before sentence for medical, psychiatric or probation report, or for enquiry as to the most suitable method of disposal. This adjournment is not to be for longer than a single period of three weeks. Section 26 provides that such a person may be remanded on bail for a report, either at a hospital such as at Balderton or elsewhere. Finally, under Section 4 of the 1948 Act, where on medical evidence the magistrates' court is satisfied that the person is not certifiable under the Lunacy Acts of 1890 nor the Mental Deficiency Acts of 1913 et seq., and that the mental condition of an offender is such as requires and as may be susceptible to treatment by a duly qualified and experienced medical practitioner, the court, if it makes a probation order, may include therein a requirement that the offender shall submit himself for a period not exceeding twelve months to such treatment with a view to improvement of the offender's condition. This section only applies to institutions, including Balderton,

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\*This article is the result of a co-operative project reflecting the team approach at Balderton Hospital. The designations of the contributors indicate the different approaches dealing with the problem of the psychopathic subnormal: (M.J.C.)—Consultant, Balderton; (A.C.)—Clerk to the Justices, Nottinghamshire; (R.M.F.)—Chief Male Nurse, Balderton; (C.M.F.)—Medical Officer, H.M. Prison, Lincoln; (H.H.)—Psychiatrist, Balderton; (C.W.W.J.)—County Medical Officer, Nottinghamshire; (L.A.J.)—Charge Nurse, Psychopathic Unit, Balderton; (D.K.)—Lecturer in Statistics, University of Sheffield; (T.L.)—Charge Nurse, Psychopathic Unit, Balderton; (P.P.)—Principal Probation Officer, Nottinghamshire; (L.S.)—Research Psychologist, Balderton.

approved for the purpose by the Minister of Health. Whilst the Act provides most helpful legal facilities for the treatment of such offenders, it is in practice extremely difficult for practitioners to find time, or hospitals to have vacancies with suitable treatment facilities. The magistrates realise that it is often asking too much to expect the probation officer to cope alone with this type of offender. Probation hostels are hardly suitable places for many of these mentally abnormal persons, and although magistrates are loath to send such offenders to prison—for they are under no illusions that in a short term of imprisonment it is possible to provide any psychiatric treatment—there is frequently no alternative, except to fine him or place him under the probation officer.

The probation officer has been described as a general practitioner in delinquency. The provision of specialist advice and in patient services by the Sheffield Region since 1948, writes one of us (P.P.), is as much of an advance for the probation field as it has been to the family doctor. It is common in this country for probation officers to struggle with quite unsuitable cases for whom the supervision he can provide does not cope with the situation at all. Treatment, or residence in a hostel, may be recommended, but due to a shortage of personnel and beds it is rarely available. Under such circumstances the probation officer often feels very frustrated, for his programme of work is distorted due to the unreasonable demands of some psychopaths and inability to attend to others who would benefit, whilst the court is apt to lose confidence in the probation service because of its failures. Ideally, the probation officer needs to be concerned with cases with which he can reasonably be expected to cope—not by any means necessarily succeed—and it must be emphasised immediately that the probation service itself does not pretend to be able to define the limits at all.

This requires in the first place a selective process by the court as to which cases should be referred to probation. It is not appropriate at this point to discuss at length the variations and difficulties which arise in this connection, except to say that the court must obviously have the fullest possible information. In the first instance it will for the most part fall to the probation officer to produce this, and much as the probation officer would welcome expert psychiatric opinion in all cases, it is obviously not practical for this to be obtained. The probation officer must be able, within reasonable limits, to diagnose those cases where specialist's help is necessary.

This provides one of the early points of contact with the specialist psychiatric services. A close understanding between the probation service and the Balderton Unit may enable suggestions to be made to the court which lead to a remand for a psychiatric report:

- (1) This may provide a prognosis that the supervision of probation should be sufficient and give an indication as to how best this can be conducted.
- (2) It may recommend probation, linked with an intensive period of hospital in-patient training. Legal provision and the Sheffield Board now makes this possible.
- (3) It may confirm the situation that the patient is unamenable to treatment and further effort in this direction could not be expected to produce results.

Thus a good working liaison between the courts, the specialist psychiatric services and the probation service can contribute enormously to a constructive policy in dealing with the problems of delinquency and psychopathy. If a patient enters the Unit the probation officer continues his personal contact with the offender but at less frequent intervals, being ready to increase visits at the end of the stay, and provide the after care services which are so important.

The probation service in Nottinghamshire has long been fortunate in the help it has received from the psychiatric specialists of the area, and now much appreciate the extra facilities designed especially for problems of psychopathy.

It is early days yet to see the outcome, and indeed this is not a field in which sensational results are to be expected, but from the aspect of the courts and the probation officer the unit has offered real help and encouragement with a group which left both bewildered and frustrated.

From the local authority viewpoint, states C.W.W.J., the disposal of high grade defectives or psychopaths in the past was not entirely satisfactory and, because of the inadequacy of appropriate hospital accommodation and training facilities, many patients waited months for vacancies, quite often (in the case of delinquents) being in prison during the waiting period on "Place of Safety" Orders, a practice which at times brought the Mental Health Service under criticism. A psychopathic unit, in addition to valuable diagnostic and treatment facilities, should make it possible to avoid anomalies in certification which might otherwise arise from difficulty in evaluating borderline cases on a brief examination. A training hospital with a unit having a rapid turnover—treatment is usually for six to twelve months—does not acquire the stigma of long-term hospitalisation, and this not only makes it easier to persuade patients to enter on a voluntary basis but ensures that vacancies are continually becoming available. As many of those admitted are adolescent dullards whose anti-social behaviour may partly be ascribed to feelings of inferiority engendered by lack of intellectual achievement, it would seem that such a unit, in addition to general training, also offers opportunities for the provision of elementary education on a more intensive scale than may have been possible in over-crowded classrooms.

Psychopaths who may be suitable for treatment in an open unlocked training unit are sometimes first remanded to the area prison, writes C.M.F., from the standpoint of its medical officer. The very fact that there is in the district an active therapeutic unit for the treatment of young psychopathic offenders who, although they are a small group, are particularly difficult, is extremely helpful towards one's whole attitude towards such offenders. While it is true that active therapeutic regimes exist in certain penal institutions and that certain mental hospitals make some effort of dealing with this type of case, it is refreshing to be able to inform a court that an institution exists whose basic aim and actual set-up is designed specifically for this purpose.

There is one group especially for whom satisfactory treatment has in the past been almost completely lacking, and that is the "sexual misadventures in the young unstable personality." Committal to prison or to other penal institutions seems to be undesirable in such cases, and one has long felt the need for a purely medical approach under institutional conditions. Balderton Hospital seems to provide a realistic form of environment and incentive, coupled with a real concern for social after-care, which is unique in one's experience.

As the recent White Paper (7) makes clear, the lines of hospital and prison are converging, for both are concerned to enable the psychopath to reduce his deviation from normal and lead a life which is enjoyable and constructive for all. It seems reasonable to hope for a future in which training hospitals provide facilities for those who can benefit from a hospital programme, whilst prisons provide treatment facilities, as at Wakefield, for those from whom the community must feel secure.

In terms of degree of severity of psychopaths, four types of treatment facilities in the community seem needed. Firstly, the family doctor, probation and mental

health officers deal with many problems concerning psychopaths backed by out-patient psychiatric specialist services as needed. Secondly, short-term facilities by way of remand are needed, so that skilled observation over a reasonable period of time is available. Remand has been held to be of treatment as well as diagnostic use. In the central Sheffield area there are remand facilities for juveniles run by the children's department, in hospitals including the unit at Balderton, and where maximum security is required, at Lincoln prison. A third type comprises open facilities specialising in treatment for the psychopath as at Balderton, and a fourth type in Home Office units such as Borstals and prisons where security is of first consideration.

The psychopathic unit at Balderton has been described in detail elsewhere (8). It consists of 30 beds available in two unlocked, open wards, one run on authoritarian lines similar to state hospitals designed for the treatment of those with some risk, such as the *fire raiser, extremely aggressive or unprincipled homosexual*, and one run on permissive group therapy lines for other psychopathic syndromes.

It is policy that those admitted are male dullards with an I.Q. 45-95, aged 14-24, who are the subject of court action and have a treatable psychiatric syndrome. None of these criteria is rigid, for if there are no other community facilities available for one who might be helped he is not debarred. In general, patients come within the definition of "impairment," advanced by the American Association of Mental Deficiency (9) in their definition of mental defectives or retardates. It has been said that approximately one-third of the patients would be diagnosed as psychopathic by each of a panel of three psychiatrists, one-third would be so diagnosed by one of them, and one-third by none at all. The last group might comprise patients with early schizophrenia, the so-called pre-psychotic schizophrenic, problems of environmental maladjustment, or adolescent sexual experimentation. Since different psychiatrists use different standards of severity in the diagnosis of psychopathic personality, as with all other psychiatric diagnoses (10), case histories may best describe at this point the type of problem treated.

Tom, aged 17, of Wechsler I.Q. 103, was sufficiently violent, destructive and dangerous to remind staff all too forcibly of similar patients in the nearby State Hospital to which at one time it had been proposed to send him. Convicted of using violence to his grandmother who had reared him, he had to be held in Oxford and other prisons pending admission. He boasted truthfully that six previous places had failed to hold him. Deserted by mother, unwanted by father, he had been hit by a car at the age of 8, and was unconscious two weeks. His further history was that of a brain-damaged person with impaired emotional control. Easily provoked, and of paranoid disposition, his excitable periods were quite unamenable to reason and he had attempted suicide twice.

Al, aged 14, of I.Q. 106, was an original homosexual prostitute from a very large family. Emotionally very immature, his attempts at homosexual seduction of staff members had caused difficulties in remand home and approved school. He was shunned and despised by fellows and feared by earlier staff. He, too, had made determined suicidal attempts.

Barry, aged 15, I.Q. 85, presented the type of arrested schizophrenia associated with six court appearances, well described elsewhere (11, 12). Fatherless, affectionless, he had been committed to a series of maladjusted hostels. Together with Francis, aged 14, I.Q. 89, Peter, aged 16, I.Q. 67, and John, aged 17, I.Q. 73, certification as defective had been considered principally for disposal. These lads were either illegitimate or unwanted, had a long series of "homes" or hostels, thieved, were violent or destructive by turns, had homosexual adventures with

adults offering affection, were friendless, embittered, cynical and often self-destructive. Much treated, they had a particular contempt for psychiatrists.

Excepting arsonists or the extremely aggressive, students were first admitted to the permissive unit styled by participants as "Camdale College." Euphemisms such as this, and "Balderton Hall Training School," had value in a hospital where elsewhere the more crippled were treated. It was explained that study consisted of development of mind and body as at higher institutions, and as each had something to contribute, each had a place on the ward council. The council, consisting of students, tutors (nurses) and a chairman (psychiatrist) ran the ward. T.L. comments that he had some doubts about the success of the system during its early stages because the majority of the disciplinary measures used by the old system were excluded, leaving one with very little power to deal with scurrility and violence. However, this problem was soon solved by the ward council, making rules to govern the unit and to deal with any offenders. It also elected ward leaders to uphold the rules and by their own good behaviour and example help others; the staff became advisers. The council has so far used much discretion when electing leaders, and only elects those who may be able to help the other members. The usual barrier between staff and patients dissolved and an atmosphere of confidence and concord substituted, which was soon turned to good advantage by the intensive practice of group therapy by doctors and nurses. Group psychotherapy is one of the principal methods of treatment, each patient belonging to the particular small group best suited to his problems. There is also a daily "points" system, members being paid for their work, attitude to others and personal hygiene on a daily pro rata basis, each point earning money. The council decided to reward those with the highest weekly totals with various privileges. There is a different social activity each evening run by students, and weekly education by a local schoolmaster.

L.A.J. continues, "The most difficult adjustment from my point of view was the changing of my position from disciplinarian to adviser. I had been trained in the old methods, but found that rigid discipline by staff was not necessary as the ward council and leaders took over and banned violence." The new role of staff meant a new and better relation with patients, but also meant that the nurses had to live up to the high standards set by the ward council, otherwise they, too, were discussed!

Although this ward was originally quite permissive, like other similar establishments a code of behaviour was soon established by the ward council. Transgressions were reported and had to be proved to the council by its leaders. Discussion is sometimes enough to deal with an offence, at other times extra work such as washing the supper dishes, is ordered. Certain offences, such as violence, carry summary punishment by way of immediate bed, for the community early decided that otherwise might would be right. Destruction is deemed to require replacement, and swearing is fined. The "swear box" is a source of joy to all, and those who swear have the bitter pleasure of seeing faces light up in anticipation of extras soon to be bought for all by their fine.

Laws or rules can be no more strict than the people who carry them out. Since nothing is barred from discussion and the ward depends on its leaders for protection, rules have to be reasonable and acceptable. There is still room under this system for some staff-suggested rules, provided that both are respected. One of these excludes alcohol from the ward.

Daily group psychotherapy conditions students to discussion of their problems both with tutors and without, and a 24-hour team of patients was waiting to discuss the reasons behind the suicidal attempt of Al (see earlier) when he recovered

consciousness. A few, such as Tom, fail to accept the unit, or after much toleration the unit fails to accept them. Such students may leave voluntarily or be required to do so. Some of these patients may be readmitted or transferred to the authoritarian ward.

The authoritarian ward is run on normal hospital lines, writes H.H., with a hierarchical basis, the staff being in unquestioned control. Although it is regarded as a ward of strict discipline by the staff, it is not necessarily regarded as inferior to the permissive unit by its patients, nor is it so represented to them. Material rewards and food are equal, and there is mixing between the two units. The noise, activity and breakage level on this ward is at a minimum, and it is clear to patients as well as staff that what may be lost on the roundabouts may certainly be gained on the swings. Treatment here is on individual lines, with emphasis on work training. The student, Tom, described earlier, who like three other brain-damaged patients failed to accept the permissive unit, transferred to the authoritarian unit, settled and is now training to be a carpenter. As with most hospitals, work training consists partly in improvement of methods of work such as time-keeping, consistency in working throughout the day, attitudes to employers, and output, partly by training in specific occupations such as farming, gardening, kitchen work, wash house operating, office work, boiler maintenance, and by arrangement with British Railways, railroad training.

From the administrative point of view, write M.C. and R.F., the permissive unit is both more difficult and time-consuming than the authoritarian unit run with individual therapy. The former poses more problems and is more demanding in time and materials. Where financial considerations and those of time or personalities are uppermost, the authoritarian has to be used. It can deal with a wider range of psychopaths both in age and degree of severity of abnormality, but loses the essential elements of group integration and atmosphere with their treatment possibilities.

Due to the amount of time required to be spent on the permissive unit by experienced and expensive personnel, as opposed to the authoritarian ward where understaffing by mental hospital standards (13) ensures that treatment is cheap, it has yet to be shown that this method of treatment is economically justifiable. To this end a research programme has been set up under two of us (L.S. and D.K.) to evaluate results.

Previous data (5, 6, 14, 15) show that both permissive and authoritarian methods of treatment are effective with psychopaths. It seems possible that different methods best suit different psychopathic syndromes (1), but neither methods nor syndromes have been adequately identified or correlated. In this light it seems morally justified in using the research device of admitting a prospective series of patients alternately to one treatment method or the other and evaluate their success. Patients would be court offenders who have non-psychotic psychiatric syndromes which were felt to be treatable in hospital. One of us (L.S.), under the auspices of the University of London's Institute of Psychiatry, has planned a battery of objective psychological tests and other devices to be administered at intervals in order to evaluate the degree and nature of change in various aspects of personality and inter-personal relationships of these patients, that may take place as a result of treatment; another (M.C.) is arranging a follow-up to assess change in employment status, reconviction rate, and other objective data, whilst a third (D.K.) has been concerned with the initial construction of this and other related projects and will be responsible for the final statistical evaluation of data.

## Summary.

A description by participants is given of a community service for psychopaths in the central part of the Sheffield region, of which a hospital in-patient unit is an integral part. A four-tier system is described, consisting of probation officer, mental health officer, family doctor and out-patient psychiatric service as the first; Home Office, hospital and other remand centres as the second; an unlocked hospital psychopathic unit as a third; and locked Home Office units as a fourth method of treatment or disposal. The fourth tier is likely to be improved in the near future by increased psychiatric treatment facilities in the area prison at Lincoln, and by the Sheffield region building new closed hospital units for psychopaths.

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