

# Security and Psychiatry: The British Experience and Implications for Forensic Psychiatry Services in Israel

Tal Bergman-Levy MD<sup>1</sup>, Avi Bleich MD<sup>2,3</sup>, Moshe Kotler MD<sup>1,3</sup> and Yuval Melamed MD<sup>2,3</sup>

<sup>1</sup>Beer Yaacov Mental Health Center, Beer Yaacov, Israel

<sup>2</sup>Lev Hasharon Mental Health Center, Netanya, Israel

<sup>3</sup>Sackler Faculty of Medicine, Tel Aviv University, Ramat Aviv, Israel

**ABSTRACT:** The courts have recently become increasingly involved in the administration of compulsory psychiatric services in Israel. Data reveal a gradual increase in the rate of court-ordered hospitalizations according to Section 15 of the Law for the Treatment of the Mentally Ill. This paper examines the implications of this trend, particularly the issues of security and safety in psychiatric hospitalization. We present highlights from extensive British experience, focusing on the implications on forensic psychiatry in Israel. We review the development of the hierarchy of security in the British psychiatric services, beginning in the early 1970s with the establishment of the Butler Committee that determined a hierarchy of three levels of security for the treatment of patients, culminating with the establishment of principles for the operation of medium security units in Britain (Read Committee, 1991). These developments were the basis for the forensic psychiatric services in Britain. We discuss the relevance of the British experience to the situation in Israel while examining the current status of mental health facilities in Israel. In our opinion, a safe and suitable environment is a necessary condition for a treatment setting. The establishment of medium security units or forensic psychiatry departments within a mental health facility will enable the concentration and classification of court-ordered admissions and will enable systemic flexibility and capacity for better treatment, commensurate with patient needs.

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order because of a questionable mental state when the crime was committed, and for those under hospitalization order for lack of criminal responsibility for the crimes for which they were accused. This phenomenon is not unique to Israel. The patient population accused of committing crimes is heterogeneous. It includes the patient in whom mental illness recently erupted and due to psychotic content attacked family members, who called the police; as well as the patient who suffers from mental illness and also has a criminal behavior pattern. Beyond the ethical question that arises from admitting both of these patient populations to the same department, as is the situation in most mental health facilities in Israel, this situation also gives rise to serious issues of security and safety. We present major points from the British discussion on this issue, focusing on their influence on the situation in Israel [Figure 1].

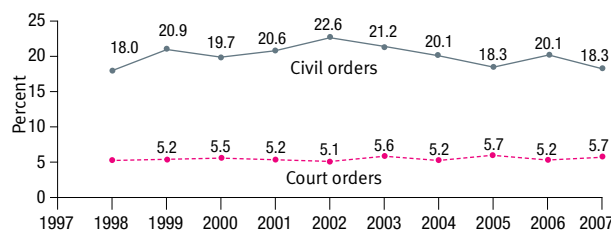
## THE CONCEPT OF SAFETY VERSUS THE CONCEPT OF DANGEROUSNESS

The concept "safety" is directly related to the concept of "dangerousness." However, while "dangerousness" represents mainly the potential to commit an aggressive act or crime and relates mainly to the individual [2], in the field of mental health the concept "safety" is a systemic aspect that includes the system of reciprocal relations between the patient and his environment. The dangerousness of the patient is reduced in the process of stabilization and recovery. Thus treatment is an integral component of the concept of safety [3].

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The courts have recently become increasingly involved in the administration of compulsory psychiatric services in Israel. Ministry of Health data in the last decade [1] demonstrate a gradual increase in the percentage of court-ordered admissions according to Section 15 of the Law for the Treatment of Mentally ill, i.e., for those unfit to stand trial, under observation

**Figure 1.** Compulsory admissions as a percent of all inpatient admissions



In the psychiatric sense, the term safety relates to a number of domains: patient safety, public safety, and the safety of the staff (caregivers). Security is an array of measures that enable safety. In psychiatry, several aspects of security are examined:

- **Environmental security** – a measure that focuses on the physical design of the unit or ward according to safety and treatment requirements. It includes construction indices, maintenance and equipment. For example, in closed wards it is necessary to plan a safe structure that enables effective observation of the patients.
- **Relational security** – a measure that relates to quality of care. It is customary to discuss the quantitative component that measures the correlation between the number of nurses on staff in the department and the number of patients, but it is even more important to quantitatively measure the percentage of time devoted by the caregiving staff to interaction with the patient. This interaction enables the development of communication and trust between the staff and patients.
- **Procedural security** – this measure relates to the methodology of security management in the facility. These regulations are generally derived from existing legislation and administrative policy. On the patient level, emphasis is on accessibility of the patient to the department, to his possessions, access to his money, and means of communication. On the organizational level, emphasis is on the planning and arrangements for emergency situations such as management of critical incidents, regulations for periods of exacerbated aggression in the ward, regulations for restraint and isolation, regulations regarding what visitors are allowed to bring into the ward, regulations for searching the belongings of the patients, etc. There must be clearly written operational procedures that are binding and accessible to the staff, in addition to the best possible judgment by staff for each specific case. These aspects are the foundation of the security hierarchy in the system [3,4].

### Forensic psychiatry has become a unique professional entity

Much time and resources have been dedicated over the years by the British government and the Royal College of Psychiatrists to the question of security of mentally ill inpatients who are accused or convicted of criminal activities. As early as the beginning of the 19th century there was a series of discussions regarding hospitalization of those classified "criminal lunatics." As a result of these discussions, in 1867 the first government asylum for convicted patients was opened: Broadmoor Hospital. Patients were sent directly to the hospital from the courts, as were prisoners who became mentally ill while in prison. Until 1930, most patients who had committed crimes were hospitalized in separate facilities that were isolated from the mainstream British psychiatric institutions.

In 1959 a policy of reducing the number of psychiatric beds in British hospitals was initiated. This became possible follow-

ing the introduction of antipsychotic medication. In the same year, British law that deals with the Mental Health Act was amended, introducing England to the modern era of psychiatry that sought to treat the patient according to the patient's free will and to respect the patient's basic human and civil rights, with emphasis on clear guidelines for involuntary confinement. The same policy led to the deferral of patient populations that were involved in legal proceedings, from most hospital facilities to their isolation in special institutions, with no facility for follow-up care after discharge [5].

A long line of committees under the umbrella of the British government and the British Ministry of Health dealt with security issues associated with the hospitalization of this patient population. In 1961, the Emery Committee assembled to discuss the issue of the security of these mentally ill patients and reached the conclusion that there was a need for security arrangements and special units for "difficult" patients in all hospitals in England for treatment, evaluation, discussion and research. The conclusions of the committee were not implemented due to lack of resources and skilled manpower.

In 1964 the Gwynne Committee Report that dealt with the organization of medical systems in prisons in England was published. The Committee recommended training specialists in the field of forensic psychiatry who were skilled in treating problems unique to that patient population. During the period 1964–1975 seven forensic psychiatrists were trained and assumed positions throughout England. Only seven hospitals thus had trained forensic psychiatrists on staff, thus the chance that criminal patients would be admitted to a hospital with a trained forensic psychiatrist was low. Since these psychiatrists functioned independently they had limited contact with all other psychiatric hospitals. In that period, there were no psychiatric units in the prisons. In 1971 the "Forensic Psychiatric Association," sponsored by the Royal College of Psychiatrists, was established [6].

In the 1970s a government trend to encourage the various regions to integrate psychiatry into the general hospitals was initiated. This process reawakened the discussion concerning security measures necessary for admitting dangerous patients (the Glancy Committee) with no distinction between criminal patients and those who were not criminals [7]. General hospitals were found to be inappropriate for the hospitalization of these patients. However, regretfully, it was the tragic case of Graham Young that created the political atmosphere that enabled change. Graham Young was a serial killer who had a fascination with the various ways of poisoning people. He was also diagnosed with schizophrenia and was hospitalized for many years in Broadmoor Hospital, the special high security mental health center. He resumed his murderous activities while conditionally discharged from Broadmoor [6,8].

**THE BUTLER COMMITTEE AS A TURNING POINT**

As a result of the above murder case, the English legislative body established two committees – one evaluated the discharge process and supervision of patients from special hospitals, and the second, the Butler Committee, dealt with the legal aspects and the hospitalization facilities necessary to treat mentally ill criminals. The Butler committee first published its conclusions in 1974.

The conclusion of the Butler committee was that it is necessary to organize the psychiatric system according to a security hierarchy. The committee recommended establishing Regional Secure Units that serve all patients, both criminal and non-criminal. These units were classified "Medium Security," ranging from hospitalization in special hospitals, e.g., Broadmoor, a maximum security hospital, to psychiatric facilities in general hospitals and additional units in the community for "Low Security" hospitalization. The committee further recommended training additional forensic psychiatrists and including forensic psychiatry in the residency syllabus. Emphasis was placed on the precise characterization of security methods, such as high staff/patient ratios (1:1 patient/nurse ratio) and appropriate planning of the hospital environment [9]. The recommendations were accepted by the British government. Initially, 1000 hospital beds were allocated for patients in medium security. The recommendations were implemented in stages. First, Interim Secure Units were established, while at the same time planning of the permanent units continued.

**It is essential to establish forensic psychiatry units in every mental health facility**

The Interim Secure Units received mentally impaired patients who exhibited "difficult" or violent behavior. The term "difficult" was and remains amorphous and is not adequately defined. These units included 15 beds and were more secure than regular closed wards, since they had double airtight doors, polycarbonate-protected windows, alarm systems and guarded exercise areas. The planned 1:1 ratio of nursing staff to patient was found to be inadequate. Gradually, multidisciplinary staffs consisting of forensic psychiatrists, psychologists, social workers and occupational therapists were developed [6,10]. Most of the units admitted prisoners and patients who were characterized by the referring hospitals as "problematic." Two-thirds of the patients suffered from psychosis, most stemming from schizophrenia. Most of the patients were transferred to these units because of physical aggression and only a minority were transferred because of non-compliance to pharmacotherapy. The average duration of stay in these units ranged from 5.7 to 12 months. The emphasis was on rehabilitation both in and outside the unit. Most of the patients were discharged to the community or to an open hospital facility, with very few referred to prison or to designated hospitals [6].

The first Regional Secure Unit opened in 1980. More than half of the funds designated by the British government for the projects were allocated by the local regions for renovation

of existing buildings and establishment of other units, and a significant portion of the funds was even assigned to non-psychiatric medical systems [11-13].

**REED COMMITTEE: DETERMINING AND IMPLEMENTING THE GOALS**

In 1991, the Review of Health and Social Services for Mentally Disordered Offenders and Others Requiring Similar Services, chaired by Dr. John Reed, published a series of reports about the existing secure facilities. To date there is still consensus in the Royal College of Psychiatrists concerning the principles determined by the Reed Committee with regard to mentally ill offenders [4]. The recommendations in the reports are based on the premise that: "care should be provided on the basis of individual need, as far as possible in the community, near to the patient's home, only at the level of security justified by the patient's dangerousness, and with the aim of maximizing rehabilitation and the prospect of independent living."

The committee determined the goal of 2000 hospital beds in Regional Secure Units [14]. In the second half of the 1980s all regions in England had beds designated for medium security units. In 1999 in England and Wales, there were close to 2000 medium secure beds, 500 of them in the private sector. Seven of the medium secure units were reviewed between 1988 and 1994, and it was found that the units provided services mainly for male patients with mental disorders who were referred from prisons

after they were accused or convicted of having committed serious violent crimes. Most of

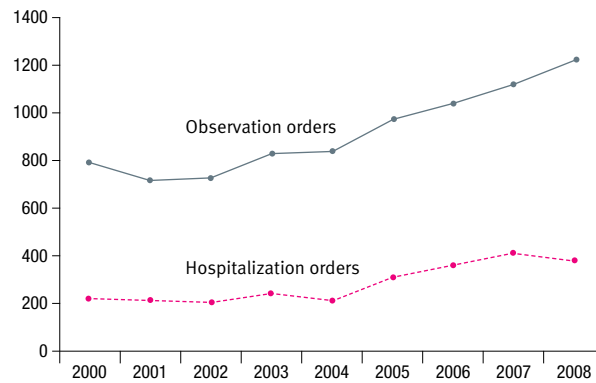
the units limited the admission of patients from special hospitals and functioned separately from them. Aside from this common denominator, these units differed from one another in other characteristics, such as demographic data, socioeconomic status, severity of the crime, hospitalization of patients from the community by civil commitment orders, rate of repeat hospitalizations, and duration of hospitalizations. The authors concluded that the development of the unit was influenced mainly by the needs of the region where it was established and was dependent on the resources and the existing services in the region, and was not a result of official national policy [15].

Issues of security and safety in the treatment of mentally ill offenders are under constant discussion in the Faculty of Forensic Psychiatry in the Royal College of Psychiatrists. This includes the activities of the medium security units and their role and the continued existence of the special hospitals

**THE SITUATION IN ISRAEL**

Figure 2 presents the number of patients who were referred by the courts in Israel for inpatient observation in mental health facilities in Israel during the years 2000–2008. The number of defendants referred by the legal system to the public mental health system has increased. This is a heterogeneous popula-

**Figure 2.** Court-ordered hospitalizations in Israel 2000–2008 (Personal Communication, Ministry of Health, Research Department)



tion of defendants, which by nature of the proceedings includes a cross-section of defendants who committed criminal acts and will be found to bear complete criminal responsibility. For the purpose of this discussion we will call this population the "criminal population." This population comes in contact with the patient population during their stay in the mental health facilities and may be a danger to them.

According to Ministry of Health data, there are 200 forensic psychiatry hospital beds in Israel [16]. Most, but not all of the beds are located in four departments in the Sha'ar Menashe Mental Health Center, in a designated maximum security unit. Mental health centers in Israel

differ in their approach to observation orders. While most hospitals use the existing infrastructure of inpatient departments where the accused under observation orders are hospitalized alongside other patients, there are a few mental health facilities that follow a structured or semi-structured model. In Israel there are three modes of operation:

- Designated forensic unit, located as part of a department. The department is a regular active ward, or designated for patients under court order, with acute or long-term patients. In this type of unit, the staff is trained for this purpose and there is usually a full-time physician whose primary job is providing expert opinions.
- Hospitals that do not have a forensic unit, where observations are performed and expert opinions are written in all hospital departments.
- A combination of the above, namely, hospitals that have designated units for observation of men only; women undergo observation in regular closed wards.

In none of the three models was there prior planning or consideration for the security needs of the staff and the

inpatients, and they operated within the framework of the existing departments. Patients are admitted under court order as part of the legal process. Some of the forensic units in Israel perform psychiatric evaluations at the request of the Court prior to the court ruling concerning issuance of the court order.

Ambulatory psychiatric evaluations that do not require observation are performed in the emergency rooms in some of the mental health centers, or in special clinics at the various hospitals. There is also a model where a hospital physician performs the psychiatric evaluation in the detention center.

## DISCUSSION

Is there a need in Israel for the English model of three levels of security for patient care? This issue became relevant in the era of the mental health reform that resulted in reduction in the number of psychiatric hospital beds and discharge of many patients to the community. This move increased the mixture of more agitated, treatment-resistant and even more dangerous patients in the hospital. Whatever the treatment setting, it cannot provide the best available care without an appropriate and secure environment. In order to perform their job well, the attending staff must feel safe in the facility, and in order to create a therapeutic relationship based on trust, the therapist and the patient must feel that they are in a protective environment that is

both flexible and not threatening.

A structured security hierarchy is beneficial in that it enables treatment of patients according to need. The security hierarchy allows

### **We have to keep public safety in mind while providing appropriate care and security for the patients and for the attending staff**

for mobility of a patient from one level to the next, subject to an improvement in his condition; a reduction in the risk of escape, of danger, of harming other patients and staff, of taking advantage of other patients in the department; professionalism and expertise of the staff in treating the forensic population, and so forth. The field of forensic psychiatry is now a more professional entity and includes the option for diploma studies in various universities, and fellowships in departments in the process of becoming recognized for that purpose. Similar specialization can be created for the nursing staff as well.

According to the extensive British experience, we must aspire to establish a forensic psychiatry department, in the format of medium security units, in every mental health center, that will serve as an interim level between maximum security units and regular inpatient departments. These units would be expressly for patients admitted by court order or for court-ordered observation. As part of the initial evaluation, risk assessment will be performed for all patients admitted to these units. If the risk level requires, the patient would be transferred to the maximum security unit at Sha'ar Menashe Mental Health Center. With completion of the initial evalu-

ation, appropriate patients can be transferred to various inpatient facilities whether in regular departments (closed or open), rehabilitation wards, or dual-diagnosis departments, and the more dangerous patients would remain in the forensic unit. This type of distribution within the hospital would specifically respond to the needs of the patients, and will protect the patients themselves, the other patients in the hospital, and the staff.

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**Corresponding author:**

**Dr. T. Bergman-Levy**

Beer Yaacov Mental Health Center, P.O. Box 1, Beer Yaacov 70350, Israel

**Phone:** (972-8) 925-8358

**Fax:** (972-8) 925-8389

**email:** Tal.Bergman-Levy@BeerNess.health.gov.il

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