The Proper Place for the Committer of a Crime is Prison Custody not Psychiatric Hospital Inpatient Care

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The issue of involuntary hospitalization in Israel is highly controversial: it is a meeting point between the medical world and the Law. With much interest I read the article by Bergman-Levy and co-authors on the British experience, appearing in this issue of the journal [1]. True, the care and treatment of violent patients is consuming a larger and larger portion of staff time. True also, that the courts are referring increasingly more defendants to the psychiatric system for diagnosis and treatment. Yet, I am not persuaded that Britain's experience is relevant to us in Israel or that we should copy their model. The size of the two populations is very different; the population mix is different, and no less different is the legislation governing the two care and treatment systems. This is not the place, I think, to set out the details of these disparities, the more so as we have yet to say a word on the economic aspect. Is the British model really worth the large financial investment required to replicate it here? This is not at all evident.

I agree that the current situation in Israel regarding this issue is not good, as I will point out later. The single psychiatric hospital in Israel with a maximum security classification is Sha'ar Menashe Mental Health Center's forensic unit. This unit's four wards and 120 beds are supposed to meet the needs of all Israel's psychiatric hospitals as well as of its own local community. It is obvious that the care and treatment of dangerous patients require special resources and a great deal of time, so it is no surprise that the Sha'ar Menashe unit gets rapidly blocked up with too many patients and no vacant beds and so becomes incapable of meeting the dynamically changing needs of the population of dangerous patients. To this must of course be added the logistic and financial hardships that the families of Sha'ar Menashe patients have to bear in order to visit the remotely located facility. The evident solution is to construct a closed forensic unit in each of Israel's six regions, *but not in every mental health center*. In my opinion these units could be either freestanding or part of an existing closed ward, provided they are designed to be escape-proof. The semantic issue of their designated security level is immaterial as long as the unit is escape-proof. The truly "difficult" patients, however, are the ones that such units will not usually be able to handle, and they will still need to be sent to the Sha'ar Menashe maximum security unit.

But the above model is certainly not the only possible solution and it is the purpose of this editorial to propose an alternative and totally different method based on ideas quite different to those driving Israel's existing forensic psychiatry care system. The core idea is that all court-ordered compulsory hospitalizations be transferred whole and without change from our mental health centers to the Israel Prison Service's custodial facilities and that patients be treated there, just as they are currently treated in the Magen Asher prison's mental health care wards in Ramle, in central Israel. The guiding principle here is that the proper place for someone who has committed a crime – even if the act is the outcome of mental illness – is prison custody and not psychiatric hospital inpatient care. I am guided by the premise that the public interest outweighs the interest of a mentally ill defendant, so that even when it is clear that he committed his act because of the illness afflicting him and in some cases is not fit to stand trial, he should nonetheless be transferred to a custodial facility equipped to provide him with all the necessary medical care in a specialist mental health care unit. After treatment and stabilization of his mental state he will then proceed, like any Israel Prison Service inmate, along the institutional track to conditional release. That is, the local District Psychiatric Board for his facility will decide, just as it currently does, whether he can be given furlough, long or short, with or without escort, or full release, or that he needs to remain in full psychiatric custodial inpatient care.

The second phase of the patient's care, shortly before his final release from custodial hospitalization, will be the issuing of a Compulsory Outpatient Care Order, which will instruct the patient/inmate to attend regular treatment sessions in his prison's outpatient clinic. This treatment will include the periodic monitoring of his state of mental health. That the treatment will take place in a prison clinic gives us the vital advantage that, should the patient/inmate not persist with his treatment or not appear for a checkup at the designated times, he can then be returned to full psychiatric custodial inpatient care, just as at present a prisoner 'on licence' who violates the conditions of

his 'time off for good behavior' is returned to prison to serve out the full term of his court-ruled sentence.

At this point, the question has to be asked how long can someone be held in full psychiatric custodial inpatient care only for violating the release conditions laid down by the District Psychiatric Board, when it converted his Compulsory Hospitalization Order (CHO) to a Compulsory Outpatient Care Order (COCO). The answer I offer is that the overall time should be the same as the length of the prison sentence the patient/inmate would have got for his offense had he not been found to be mentally ill.

I am fully convinced that the change in the systemic approach proposed here will not only solve the problem of our current 'toothlessness' in enforcing Compulsory Outpatient Care Orders, it will also prevent a relapse into the psychotic state for which the patient/inmate was hospitalized in the first place. I also expect that a further favorable side effect will be fewer applications to courts by defense lawyers for psychiatric examination orders, the alleging of insanity being their customary first line of defense on behalf of their suspect/detainee client. This practice of defense lawyers puts an unnecessary and unjustifiable burden on both the courts and the psychiatric care system. For this reason alone – to stop the cheapening of psychiatric examinations – I have been campaigning for years for the proposal put forward here, but unfortunately with no success.

I hope that my response to the article by Bergman-Levy et al. will, at the least, provoke a productive discussion of the issue in question. A sharp sidelight is thrown on it by the Haifa District Court's [2] ruling a few months ago that the proviso of insanity does not apply when the psychotic state obtaining when an accused person committed his criminal act stemmed from the abuse of, or withdrawal from, drugs. For the insanity proviso to apply, the court has ruled, it must be shown that it was by reason of mental illness not by reason of drug addiction that the accused lacked the capacity to stop himself committing the act in question. Before this ruling, accused persons who, when they committed an offense were in a drug abuse-induced psychotic state, were sent to a mental health center under Article 15 of the Mental Patients Treatment Act. Was there any justification for this practice? Of course not. Such offenders should be sent to an Israel Prison Service custodial facility and have their psychotic state treated there. I am gratified that the courts have now reached the same conclusion and I only hope that this ruling will lead the psychiatric treatment system to change its stance on the issue discussed here.

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