Clinical Criminology

From Psychiatry to Clinical Criminology

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This paper describes 24 years of psychiatric treatment within the prison service in
Israel. During that period, there have been many changes in structure and scope
of mental treatment of prisoners and in the manner in which its function was
conceived. Initially, such treatment was provided by a small team with a penal and
medical-pharmacological orientation; by now, the team is large, has a broad
psychotherapeutical orientation and develops new approaches and working
methods.

At the beginning of the period under review, treatment was mainly clinical
provided within a hospital unit and the clients were psychotic prisoners; by its end,
treatment is provided in a center for mental health and clinical criminology, and
the clients are the entire prison population, staff as well as prisoners.

The various stages of this development were not achieved without struggles —
in fact, some of these still continue — but a look at the past and a review of its stages
may provide a better insight into the structure and philosophy of the Center as it is
today. Its development is paralleled by similar developments in the world at
large. A discussion of these stages may provide interesting material for many
colleagues for purposes of comparison with developments in their institutions and
of a better understanding of the function and nature of mental care for prisoners
in the corrective institution.

1954–1959

In 1954, after an organized riot in the Neve Tirza women’s prison ascribed to
mental disturbance among the rioting inmates, the Knesset passed a resolution
calling for the establishment of a Psychiatric Department in the Prison Service. By
agreement between the Ministry of Health and the Ministry of Police, a hospital
unit was also established. The Department, including the hospital unit, was part of
the Medical Branch of the Prison Service. The staff consisted of one psychiatrist,
one social worker, four practical male nurses and six warders.
Thus, in effect, a psychiatric team set foot in the prisons for the first time in 1954. The team soon realized that the prison population included many psychotics, who needed appropriate psychiatric attention. Until the team appeared on the scene, these prisoners had been under the care of the general practitioner.

The targets assigned to the team by the Prison Service were:
1. To transfer the psychotic prisoners to a mental hospital, the view being that this was the place for mental patients.
2. To deal with prisoners defined by prison officers as disturbing elements.
3. To write reports for administrative bodies and committees.

In the first three years, the main task of the Department was to deal with mentally disturbed prisoners whose noisy behavior made them a nuisance in prison. These prisoners were in due course transferred to outside institutions, thus making room in the hospital unit.

After the psychotic inmates had been transferred, a dialogue began between the prison authorities and the psychiatric team. Differences of view as to the nature of the Psychiatric Department's function became apparent.

The Prison Service demanded that the Psychiatric Department should keep the hospital unit filled up and admit prisoners defined as "education-resistant"—meaning that the regular prison staff was unable or unwilling to make these prisoners function normally and expected that this would be possible, or at least that they could be isolated and thus the prisons would be able to function normally, through the intervention of the psychiatric team. The team, on the other hand, felt that admission and treatment should be available preferably for prisoners suffering from mental disorders, even if their behavior was not necessarily disturbing.

Concurrently, there also emerged conceptual differences between the general prison service staff and the psychiatric team on the one hand, and the Ministry of Health on the other hand, about the placement of mentally disturbed prisoners. The Ministry did not allow these to be admitted to its hospital facilities. No formal decision was taken, but in practice no transfers were effected. The mentally disturbed prisoners remained in prison, in the hospital unit of the psychiatric department.

Admissions to the Department in those times were pragmatic and ruled in equal measure by the views of the Prison Service and those of the psychiatric team. As a result, the character of the unit was highly heterogenous.

The hospital unit was located in the most secure part of a maximum security prison, in its very center. It consisted of four cells in which the prisoners were locked up for most of the time, a medical orderlies' room and an occupational therapy room. In these four cells 42 patients were kept. Food was thrown in, or pushed in under the door.

What was characteristic for this period was that professional activities were confined mainly to writing reports, diagnosis and medication, the general approach tending to be punitive. Psychopaths were not admitted for treatment; the general approach in such cases was to instruct the prison staff in their penal treatment.
1959–1963

In 1959 a second psychiatrist (the present director of the Center) joined the staff of the psychiatric department. During this period, we still find the diagnostic approach continuing, but with the first beginnings of a therapeutic approach.

There were during that period three main attitudes on the function of the psychiatric department in the Prison Service:

1. The attitude represented by the head of the Medical Branch and the head of the Prison Service Psychiatric Department at that time, which was based on the classical medical model, with the accent on medicinal and institutional (not ambulatory) treatment.

2. The attitude by the Social Service: a therapeutic approach, according to which care for the criminal population was the task of the social worker, while the psychiatrist’s duties were confined to those of a mere diagnostic consultant.

3. The approach represented by part of the psychiatric team: a broad approach including care for the patients and care for the community. This approach favoured ambulatory treatment without medication for the patients, operating among the prison community in general through the Chief Warden [1].

These differences in approach led to a great deal of conflict and friction. The Prison Service supported the view of the Social Service and continued to refer disturbing elements to the unit for hospitalization, whether they were mentally ill or not.

However, there were a number meaningful developments during this period:

1. The professional staff was expanded. Specialists in additional fields joined the team — an occupational therapist, a psychologist, and a medical secretary.

2. Team work began to develop and two teams took shape: one with a psychotherapeutical orientation, consisting of the junior psychiatrist, the psychologist, and the other with a medical-chemotherapeutical orientation, which included the head of the Department, the male nurses, and the occupational therapist.

3. One of the psychiatrists made the roads of all prisons for examination and follow-up of patients hospitalized in the department, and also engaged in instructing and guiding the prison administration and therapy staff (medical orderlies) on the spot.

4. Within the hospital unit a therapeutic unit was established for the first time, in which all inmates of the unit who were not psychotics took part.

5. An attempt was made to allow the inmates of the unit to engage in autonomous activity. Because of considerable opposition among the team, this attempt was given up before it got off the ground.

6. The Department was transferred to a less central and larger wing of the prison, conditions in general improved, and an additional occupational therapy room, a dining room, etc. were added.

7. Professional cooperation developed with the Beer Yaacov mental hospital. At this time there was a controversy within the team, and with the prison staff, on a point of principle connected with the definition of the psychiatric profession: whether it is a medical or psychological discipline. In administrative terms, this involved the question of whether the Department should belong to the Medical Branch, or whether a Mental Health Center separate from the Medical Branch should be established.
1965–1970

During this period one can discern the first signs of the components which characterize our work now: a therapeutical rather than pharmological accent, out-patient group-therapy working with people with behaviour disturbances, research and teaching at the university, and development of contacts with institutions and organizations on the international level.

During this period, the management of the Department changed, and the junior psychiatrist was appointed Director of the Psychiatric Department. Characteristics of the period were the following incipient developments and changes:

1. A therapy group started operating outside the hospital unit. It was formed contrary to the position of the prison authorities. The social workers were also not in support of this group work, but were willing to let us work with cases in which the prognosis was unfavourable. A highly heterogeneous group was thus formed, including paranoid, aggressive, homosexual and Arab nationalist prisoners. It was the first time that a woman served as co-therapist in a therapy group in prison.

2. The Director of the Psychiatric Department was invited to join the faculty of the Criminology Department of Bar-Ilan University. Towards the end of the period, in 1970, a Criminological Institute was established at the Tel Aviv University, and our academic activities were extended to this Institute as well.

3. A beginning was made with research work, and three clinical research projects on group work and violence were completed and published [2–4].

4. A major therapeutic and human achievement was the transfer of psychotic patients to hospitals outside the prison. Admission to the Department for therapy consisted of prisoners with behaviour disturbances.

5. Relations of mutual exchanges of knowhow and information were established with social therapy institutions abroad, mainly in the Netherlands and Germany.

Physical conditions took a turn for the worse; the Department was moved from its previous location to a small, cramped wing, which had previously contained the solitary confinement cells; a narrow passage without any rooms. Conditions in the Department became very crowded.

During this period, there were two prevailing views as to the manner of functioning of the Psychiatric Service in prison:

1. The broad approach: activities should be in the form of a comprehensive country-wide service (which was the actual situation).

2. The narrower approach: the service should operate in the central part of the country only, with outlying prisons under the medical supervision of the District Psychiatrist of the district in which the prison is located. This view did not gain acceptance, mainly because of the attitude of the psychiatrist to therapy for prisoners.

An attempt was made during this period to bring about a functional union between the social and the psychiatric services. The Director of the Psychiatric Department was placed in charge of both services. This situation continued until 1971, when the previous pattern of two separate services was resumed.
1971–1973

Characteristic of this period is a general expansion in most fields in which activities had begun in the previous period. At the same time, the tasks of the Psychiatric Department were redefined.

In effect, this period is a transition between the stage of the Psychiatric Department and the psychiatric approach, and the stage of the Mental Health and Criminology Center with its clinical criminology approach. Attempts were made to develop group work and wide-branching academic activities, but these were still of the order of empirical experiments and were not yet guided by a consolidated theoretical approach.

In this transitional stage, several changes occurred in the Psychiatric Department which represented first steps in the development of a Mental Health Center: the nursing staff was enlarged, and additional psychologists and criminologists were engaged. These were the first criminologists to become part of the therapy work structure. They shared in the different activities of the Department. The number of therapy groups operating inside and outside the Department increased. Academic activity expanded. At the Criminological Institute, a clinical division was established which offered two new courses for students. The students took part in the demonstration of cases and in therapy groups in the Department.

There were further events and developments during this period. An expert committee was formed to examine the function of the Psychiatric Service within the Prison Service. Its main conclusion was that the existing framework needed to be expanded and there should be a transition from institutional clinical psychiatry to community psychiatry, while preserving the existing format of a national service.

On the basis of the committee’s conclusions, an agreement was reached between the Prison Service and the Ministry of Health, under which mentally diseased prisoners would be admitted to the Prison Service hospital unit and not transferred to outside institutions. To compensate for this, the personnel establishment of the Psychiatric Service was increased to 36. Most of these appointments were assigned to nursing staff, and were in due course converted to appointments for criminologists and psychologists.

The Department was relocated once more to a separate location where it still operates as a separate unit. At the end of this period, in the spring of 1973, a criminological research team became operative. The research of this team provided the basis for extensive research activity in the field of clinical criminology.

The Yom Kippur War (October 1973) abruptly interrupted this activity. Most of the students were called up for military service and did not return to the Center.

1973–1977

At the beginning of 1974, the status of the Psychiatric Service was changed. From being a Psychiatric Department, it now became the Prison Service Mental Health Center. The change in name and status went hand in hand with a change in the
nature and conception of the Center’s function. This was now envisaged in terms of a broad model and defined as care for the general mental health of the correctional institution, rather than in terms of the old, restricted view of the medical psychiatric model.

In the context of the Center’s activities, a clinical criminology team was formed, consisting of the Director of the Center, the research team, and criminology graduates staying on as members of the Center staff. In the first stage, the work of the criminological team was concentrated mainly within the hospital unit, but branched out in the direction of the general prison system.

This period is characterized by the beginnings of systematic team work for experiments in conceptual thinking and the shaping of clinical criminology as a profession in its own right. These experiments were accompanied by theoretical development and by the development of techniques capable of being implemented in the field. The team had to cope with several problems at one and the same time:

1. The attitude of the old staff – nursing, therapy and security personnel – to the clinical criminologists was ambivalent. They agreed to accept them as a research team which was expected to engage in research and theory and demanded that they should acquaint themselves with work with the prisoners, but objected to this being done within the hospital unit. The argument was that criminology as a discipline was not one of the recognized therapy sub-disciplines, that it was a discipline lacking professional ethics, and that the criminologists were lacking in professional knowledge. Another argument was that criminologists tended to over-identify with the prisoners under treatment and therefore were a restricting element within the Psychiatric Department.

2. The social workers claimed that their work and that of the criminologists overlapped, and regarded themselves as more highly skilled than the criminologists and felt that their field of work was being invaded from all sides.

3. The psychologists’ reaction was also adverse. They did not regard clinical criminology as an equal partner for purposes of joint discussion and work, because of the lack of appropriate training and of an appropriate approach, and the absence of psychotherapeutical experience. This fight for existence proved very helpful to us in shaping and defining the field of operation and creating the framework of clinical criminology.

At the same time, the psychologists objected to working with psychotics only and sought an additional field of activity within the prison. The classical approaches and traditional tools of therapy are not suitable for the specific population found in prison, which made it difficult for the psychologists to widen their field of action. These concurrent problems faced by psychologists and criminologists provided common ground for the two professions.

Joint work teams of criminologists and psychologists were established and operated in all prisons within the Green Line. The view which developed was that the function of these teams was not restricted to dealing with psychical cases, but should be expanded so as to include the population and defined as diseased.

Within these teams, there were differences of opinion between the psychologists and the criminologists. The psychologists regarded themselves as an outpatients’ branch of the psychiatric unit, while the criminologists did not
conceive of themselves in this manner, but wanted to treat the problematic prisoners in cooperation with the local therapy and security personnel of the prisons. Their view of the Center was that it was a criminological rather than a psychiatric-medical facility. Nevertheless, progress was achieved towards the development of a joint conception, with the psychologists admitting the need to treat prisoners suffering from behaviour disorders [5].

Conclusion

This paper presents an attempt to describe the different stages in the development of the Center for Mental Health and Clinical Criminology. In the world at large, there is at present a regression in the way in which care for prisoners is conceived of, with an increasing accent on the punitive-deterrent aspect.

In our opinion, part of this regression is due to frustration on the part of the society and those providing the care, caused by low prisoner rehabilitation rates or high relapse rate, which have not changed with the change from the punitive to the therapeutic approach. The frustration of the therapists is particularly marked because the criticism comes from both sides: from the community at large, and from their colleagues who do not deal with prisoners and work with traditional methods and classical concepts.

The Center is an institution which has developed from a medical-therapeutic facility based on traditional-classical theories and approaches, to an institution with innovative and experimental approaches to therapy. Selffeedback and self-support on the one hand, and the development of therapy approaches which are beginning to prove themselves, result in a low frustration level. We of the Center hope that our experiences, which are described in this paper, and additional sections of which have been described in other studies by us, will give rise to discussion and interest among professionals in the field, and help us to develop ourselves and our work in new directions, and may perhaps also prove helpful to others who will follow our lead in similar directions.

References