
The Israel National Institute for Health Policy Research

In collaboration with The Israel National Council for the Rehabilitation
in the Community of Persons with Mental Dis

# Rehabilitation and Community Integration of Persons with Psychiatric Disabilities: The First Ten Years and Beyond

## International Workshop Report

**Editor: Uri Aviram**

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# Forewords

Honored audience*,

First I would like to thank you for your will readiness to study the impact and the results of the law of rehabilitation of the mentally disabled.

The process of legislating the law of rehabilitation of the mentally disabled people was arduous and long – three years long. I would like to take this opportunity to thank, once again, all those who helped put the law together and overcome the obstacles, and specially – to include in the law the detailed services' package.

The Basic Law on Human Dignity and Liberty is not mentioned in the law's preamble as pure ornamentation. My starting point and that of many who helped me was the concern for the liberty and dignity of the mentally disabled. But a right, if it is not to remain on paper, must be supplemented with an obligation on the side of society, of the state, of the government, to practically protect – through real integration, budget allocations, buildings – the right of the mentally disabled to live among us, and as far as possible – like us.

An important aim of the law was to respond to the unique characteristics of the mentally disabled, which had prevented them from receiving proper address of their needs in the services given to other disabled and handicapped people by the Welfare Ministry. In preparing means to address this uniqueness, we were helped immensely by the Health Ministry, and especially by the Rehabilitation Office headed by Yehiel Sharshavsky.

The decade that has passed proves the truth of the basic assumption underlying the law: that the rehabilitation of the mentally disabled is a social and moral duty for a society struggling against discrimination and promoting equality. It also proves, that a social and moral act can be economically viable, as it enables us to transfer funds from hospitalization to integration in work and living in the community.

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* Greetings at the opening session of the International Workshop, Rehabilitation and Community Integration of Persons with Psychiatric Disabilities: The First Ten Years and Beyond, The Israel National Institute for Health Policy Research, October 13-14, 2010, Caesarea, Israel.

The social and individual impacts of the law are the result of the dedicated every day's work and energies, of the exalted labor of community rehabilitation of the mentally disabled. You, working in the field of rehabilitation, have proven that the law is not wishful thinking, but a practical way of rehabilitating the disabled, improving their quality of life and realizing their right to be an integral part of the community.

The rehabilitation of tens of thousands of the mentally disabled in the last decade is a great achievement, but one that does not guarantee that the law will not once again be put in danger. My wish for the mentally disabled and their families, for the rehabilitating organizations, for the therapeutic teams and the Ministry of Health, is that through joint action, you will manage not only to prevent any attempts to make cuts in the existing law, but also to extend the service package, so that more and more groups of the mentally disabled will be included in it.

All that we ask is to liberate ourselves from prejudice and to provide human beings a real chance to live in dignity.

**Tamar Gozansky**
*Former member of Knesset*

# Greetings

In July 2000, Israel's Knesset legislated the "Rehabilitation in the Community of Persons with Mental Disabilities Law" (RMD). This important legislation was expected to have a significant and direct impact on the health, rehabilitation, and welfare of individuals suffering from limitations resulting from psychiatric disorders. One of the goals of RMD is the transfer of full responsibility for mental health services to the health funds, which has not yet been accomplished, and as a result remains the responsibility of the Government.

It is well known that mental health issues have many ramifications on physical well-being and are therefore appropriately an integral part of the health services system. The mental health system functions as an integrated system with the general health system, and as a result RMD and other reforms that followed have had direct consequence on both the mental health ambulatory and hospitalization systems, as well as on the general health system.

In accordance with its mission to research and advance issues related to the 1995 National Health Insurance Law, of which RMD is an extension, the Israel National Institute for Health Policy Research saw fit to mark the 10th anniversary of RMD's passing by organizing an international workshop to discuss and evaluate RMD's implementation and review plans for the future.

"The Rehabilitation and Community Integration of Persons with Psychiatric Disabilities: The First Ten Years and Beyond" International Workshop was expertly organized and chaired by Prof. Uri Aviram in cooperation with the Israel National Council for the Rehabilitation in the Community of Persons with Mental Disabilities  W e believe that it is important to learn from the experience of others; to deliberate with international experts on topics facing the system; and determine how we can improve the service. Four senior experts in the field, two from Britain and two from the US, accepted our invitation to participate in the Workshop. Approximately 50 policy makers, researchers and leading authorities in the field of mental health rehabilitation participated in the Workshop during the two very fruitful days of deliberations.

It is my hope that this book, which summarizes the Workshop's proceedings, will enrich our understanding of the issues and contribute to the improvement of both mental health services and other health services in general.
Sincerely,

**Prof. Shlomo Mor-Yosef**
*Chairman, Israel National Institute for Health Policy Research*

My dear rehabilitation professionals,

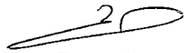
I welcome your initiative to document the outcomes of the workshop on expanding the rehabilitation aid offered to people struggling with mental illness.

It is a highly symbolic and meaningful coincidence that at exactly the same time as your workshop and not far away geographically, the senior management of the Ministry of Health were meeting to compile a list of the Ministry's 'guiding stars' , the multi-year, continually renewing agenda of objectives and tasks the Ministry sets itself.

To reinforce public medicine and reduce healthcare inequalities was one of those 'guiding stars' fixed on at our meeting. Thus these two planning for a simultaneously raised the flag of paying attention to population groups too little listened to, population groups who will be served only by a committed orientation to values and not by obedience to 'market forces'.

Further, I set down here my own profound personal commitment to continue working to reinforce the capacities and resources of the mental health rehabilitation system. I salute your public-spirited work and draw inspiration from it.

With my warmest wishes for your continued success,



Prof. Ronni Gamzu

Director General



The document before you is the final product of the Workshop in which the most outstanding individuals in the field of psychosocial rehabilitation and academia from the United States, England and Israel participated this last fall. This effort is summary of a most important event which each of the participants and the readers of this report has the opportunity to take advantage of all the information that was presented , and the potential to use it to influence and contribute to their work in the field.

Rehabilitation is characterized by its originality and creative thought process, while assisting and advancing the individual living with a psychiatric disability.

The contribution of academic research and theory to the daily practice of professionals working in rehabilitation, was the basis for this Workshop.

I would like express my deepest gratitude to all of those who work day in and day out in rehabilitation, and most expressly to Professor Uri Aviram, who was the guiding force behind this conference as well as this document.

**Dr. Gad Lubin**

*Head, Mental Health Services*

*Israel Ministry of Health*

# Introduction

# Rehabilitation and Community Integration of Persons with Psychiatric Disabilities: The First Ten Years and Beyond

## Introduction

On July 11th 2000, Israel enacted the Rehabilitation in the Community of Persons with Mental Disabilities Law (RMD). This major social policy change, defined as the Rehabilitation Reform, reflects and has generated one of the major changes in the structure and delivery of mental health services in Israel. The Israel National Institute for Health Policy Research in collaboration with the Israel National Council for the Rehabilitation in the Community of Persons with Mental Disabilities decided to mark the 10th anniversary of this law by holding an international workshop in order to assess the first ten years and plan ahead.

A small group of persons of those who have been involved in leading the rehabilitation reform gathered in Caesarea for a two days workshop on October 13–14, 2011 to review the experience of the first decade since the implementation of the law and to discuss issues and challenges confronting the mental health rehabilitation services as the reform enters its second decade. This group included government decision makers, legislators, researchers, academic instructors, practice leaders as well as users and family members.

## The focus of the Workshop

A policy change is not completed with the enactment of a law. In fact, this is just the beginning. The implementation phase is as important as the legislative act. During the implementation of the law many issues and challenges emerged, many of which could not be predicted. In a broad sense, the major issues are related to the target population, the financing of the services, the services themselves and the interrelationship with the task environment of the major societal efforts at rehabilitation of the mentally disabled.

As the system was entering its second decade we decided to use this opportunity to stop for a moment and take a look not only at what has been achieved but also at what went wrong and what should be corrected. A midterm

assessment is necessary, to identify what are the problems and what can and should be rectified.

This was indeed the purpose of this workshop. Since there were many issues to be dealt with and time was limited, we decided to concentrate on what might be considered as some of the most essential ones. Also, we decided to concentrate on those issues that we felt it would be most beneficial to draw on the experience of other countries.

Thus, the two foci chosen for this workshop were:

a. Integrating rehabilitation services for persons with psychiatric disabilities with the other components of the social services, and especially mental health, health and the welfare services.
b. Rehabilitation, recovery and integration in the community of persons with psychiatric disabilities.

Recognizing the importance of learning from the vast amount of knowledge and experience gained elsewhere, we were fortunate that four internationally renowned mental health and rehabilitation experts agreed to join us for this workshop, sharing with us their knowledge and expertise. Two of our guests came from the United Kingdom and two from the United States. Although each country is unique, and its social and health systems reflect the local culture and circumstances, much can be learned from the knowledge accumulated and the experience gained by other jurisdictions. The U.K and the U.S.A have achieved remarkable changes improving the care and treatment of persons suffering from mental disorders. However, their systems are not free of problems and they have to continuously cope with major issues in their efforts to improve the service system and the quality of life of those they serve. There is much we can learn from these countries' achievements as well as from the problems they have been dealing with.

The international experts were:

- Robert E. Drake, Professor of Psychiatry and Community and Family Medicine at the Dartmouth Medical School and the Director of the Dartmouth Psychiatric Research Center, USA.
- Michael Hogan, Commissioner of Mental Health of the State of New York, USA.
- Mike Slade, Reader in Health Services Research at the Institute of Psychiatry, King's College, London and a Consultant Clinical Psychologist in South London, U.K.



- Graham Thornicroft, Professor of Community Psychiatry and Head of the Health Service Research Department at the Institute of Psychiatry, King's College, London, and a Consultant Psychiatrist in a community mental health team in South London, UK.

Nine Israeli experts were actively involved in the Workshop, in presentations, chairing session and leading discussions. The Workshop was greeted by Mrs. Tamar Goz'ansky, former member of the Knesset, who initiated and led the process of legislation of the RMD law. Following, Dr.Gad Lubin, Director of the Israel Mental Health Services, greeted the audience. Two Israeli experts provided background and assessment of the first decade of the Israeli RMD law.

- Uri Aviram, Professor Emeritus of Social Work at The Hebrew University of Jerusalem, and the Chairperson of the Israel National Council for the Rehabilitation in the Community of Persons with Mental Disabilities, Israel.

- Yechiel Shrereshevsky, Israel National Head of the Psychosocial Rehabilitation Unit, Mental Health Services, Ministry of Health, Jerusalem

The chairpersons of the sessions and the discussion leaders were:

- Alexander Aviram, Scientific Director, The Israel National Institute for Health Policy Research, Tel Hashomer

- Yigal Ginath, Associate Professor of Psychiatry, Ben Gurion University and Chairperson of Reut, Community Mental Health Organization, Jerusalem

- Moshe Kotler, Associate Dean for Medical Education at the Sackler Faculty of Medicine, Tel Aviv University and the Director of the Beer Yaakov-Ness Ziona Mental Health Center.

- Shlomo Kravetz, Professor Emeritus in the Rehabilitation Psychology Program in the Department of Psychology at Bar-Ilan University, Israel.

- David Roe, Associate professor, Chair of the Department of Community Mental Health, Faculty of Social Welfare and Health Sciences at the University of Haifa, and an adjunct associate professor at the Department of Psychiatric Rehabilitation and Behavior Health Care, School of Health Related Professions, University of Medicine and Dentistry of New Jersey.

- Eliyahu Shamir, Chairperson of the NGO, Ozma– Israeli Families of Persons Coping with Mental Illness and Professor Emeritus of Mathematics and Computer Sciences, The Hebrew University of Jerusalem.

The framework of the workshop consisted of several presentations followed by panel discussions of the international experts and general discussions of all the participants. Following I will provide a short introduction of the RMD law; comment on the focus of the workshop and describe briefly the presentations that took place during the two days workshop and what are presented in these proceedings.

## The Law of the Rehabilitation of the Mentally Disabled in the Community

The Law of the Rehabilitation of the Mentally Disabled in the Community is one of the most important social laws enacted in Israel in the last several decades and one of the most progressive of such laws internationally. Its basic tenets are the provisions of entitlements to rehabilitation service provision on the basis of defined eligibility criteria (see appendix for the English translation of the law).

As clearly stated in the law, its purpose was to strive for and advance the rehabilitation and integration of the mentally disabled in the community in order to allow them to achieve the maximum degree of functional independence and the highest possible quality of life, while preserving their dignity in the spirit of the Basic Law: Human Dignity and Liberty.

According to the law every person of 18 years or older who is recognized by the National Insurance Institute as having a medical disability of at least 40% and who is referred by a psychiatrist, is entitled to apply to a Regional Rehabilitation Committee to request psychiatric rehabilitation services. The committee, composed of three mental health professional workers,, is authorized to make a professional assessment and to decide upon a package of rehabilitation services which the individual will be entitled to receive. This package ("basket" in Hebrew) includes an individually tailored compilation of services and programs as listed in the law, including housing, employment, adult education, social and leisure time activity, assistance to families of the mentally disabled, dental care and case management.



The law established a National Council whose task has been to monitor the implementation of the law and advise the government how to further develop rehabilitation services for the mentally disabled. Another feature of the law is the clause requiring the executive branch to seek the approval of the legislature for any change in the package of services the government may want to introduce.

The enactment of the RMD law was made possible by a configuration of factors, including a coalition of policy makers, legislators, professionals, families and users of services and other interest groups involved in the process and, of course committed leadership, as well as circumstances and opportunities for a policy change. It is beyond this introduction to assess the reasons and circumstances that brought about this legislation and the changes that have occurred. However, it is important to note that the Department of Finance supported the reform and made a commitment to finance its implementation. This support has been a necessary condition, though not the sole one, for the implementation of the rehabilitation reform.

Whereas some of the supporters of the rehabilitation reform considered it as merely a less expensive substitute to mental hospitalization, many others viewed it as an important milestone. They perceived it as a sign of a fundamentally new approach to persons with mental disabilities that reflected a societal commitment to offer persons with serious mental illness rehabilitation services which could contribute to improving their quality of life while facilitating their recovery process.

## The Workshop

In order to set the stage and provide background on the Israeli mental health rehabilitation system, the workshop started with a brief description of the rehabilitation law and its implementation, illuminating its principles, trends and issues, assessing the services after a decade of operation as well as the major dilemmas that have arisen during this period.

Uri Aviram presented the principles of the RMD law and the challenges confronting the rehabilitation service system as it enters its second decade. He emphasized the unique and progressive principles of the RMD law that entitled persons to apply for a package of rehabilitation services defined by the law and the fact that assigning the services is based solely on professional considerations.

As he reviewed the dramatic progress in rehabilitation services, reflected in the increase in the number of persons receiving rehabilitation services and the dramatic expansion of the budgetary allocations for these services, he also pointed out that the rehabilitation reform has been one of the major factors facilitating the significant reduction in the rate of psychiatric hospitalization in the country. However, as the rehabilitation services expanded, ambulatory services suffered a set-back, and the long awaited transfer of mental health services to the general health care providers had not yet been accomplished. Since the components of mental health services are interrelated, he warned that these problems and delays in completing the comprehensive mental health reform endangers the continued success of the rehabilitation reform. He also felt that the present attempt to link the pending mental health reform bill to revision of the RMD law would be a major blow to the rehabilitation law and must be prevented.

Yechiel Shereshevsky focused on the impressive growth of the rehabilitation services during the decade since the enactment of the RMD law. Since the early inception of the program, approximately 30,000 individuals received rehabilitation services in the community. Currently, about 16,000 individuals receive these services in the community from many different types of services. Another indication of the significant transformation of the system is the increase of the budget devoted to rehabilitation and the increased portion of rehabilitation services in the total mental health budget. He discussed the challenges faced by the system including the need to amend certain parts of the package of services, the adjustments necessary to cater for needs of young persons and the critical importance of monitoring and assessing outcomes of services. He concluded his presentation with comments about the adverse effect of the stigma on the efforts to rehabilitate and integrate mentally ill persons in the community and the actions needed to address this problem.

The second session of the Workshop was on the integration of rehabilitation services for persons with psychiatric disabilities with the mental health and the welfare systems and was devoted to the American and the British experience on these matters. Michael Hogan presented on the American experience and Graham Thornicroft talked about the experience in England. This session was followed by the third one focusing on what Israel can learn from the American and the British experience.



Michael Hogan argued that as mental health services move from hospital to community the challenge of coordinating or integrating services became much more complex. He pointed out that the problem of integration is possibly even more complicated in the U.S. than in other jurisdictions because the American governmental system is decentralized-both politically and organizationally. He talked about the emerging paradigm of "Recovery" and how it alters perspectives on services creating on the one hand new problems of coordination but also presenting promising opportunities for better services.

The main aim of Graham Thornicroft's paper was to highlight the development and content of current community care policies in English adult mental health services. He focused on the historical development leading to the present English government policy and guidance for mental health services. He presented a brief overview of the recent policy and legal changes that constitute key milestones in the development of community and hospital care policies. In discussing the concept of balanced care he emphasized that mental health services should be provided in normal community settings, as close to the population served as possible, and where admissions to hospital can be arranged promptly when necessary. His presentation also addressed the issue of how to resolve some of the frequent barriers to service improvement and related to overall lessons learned in developing community care systems.

The second day of the Workshop focused mainly on the second theme, namely, rehabilitation, recovery and integration in the community of persons with psychiatric disabilities. Robert Drake's presentation focused on evidence-based rehabilitation and recovery practices, and Mike Slade talked about the conceptualization and implementation of the recovery orientation.

Robert Drake reviewed five evidence-based psychiatric rehabilitation interventions that have been commonly used to promote rehabilitation and recovery among people with serious mental illnesses in the U.S: illness management and recovery, integrated treatment for co-occurring disorders, assertive community treatment, family psycho-education, and supported employment. He generalized from them to current trends in the field, and linked psychiatric rehabilitation to the recovery movement. He pointed out that despite extensive research support, these five practices were not widely implemented and are in some ways controversial in the U.S. He reviewed the barriers to broad implementation of these practices and discussed current research strategies for refining interventions.

Mike Slade devoted his presentation to understanding what recovery means and how to support personal recovery. He defined the concept, described the meaning of this new paradigm in the mental health services arena, and stressed the ethical and scientific basis for it. He further emphasized the evidence for its implementation by illustrating this new approach through international case studies. He identified the challenges faced by mental health worker and the service system that need to adapt to new practices that are based on the Personal Recovery Framework.

Before I conclude, I would like to mention that the entire workshop was filmed and can be watched on the website of ISPRA–Israel Psychiatric Rehabilitation Association. The link is:
http://www.ispraisrael.org.il/Web/Knowledge/Video/Course/Default.aspx

The assessment of the Israeli experience of the rehabilitation reform in light of the lessons from the British and the American experience and the exchanges that took place during the two days workshop provided important ideas and guidelines for the next decade of the implementation of the Israel RMD law. The Israeli experience of the rehabilitation reform may also serve as a case study for other jurisdictions attempting to reform their mental health services by promoting rehabilitation services and the recovery orientation. I hope that these proceedings add to the knowledge gained through the Workshop and will be useful to all those involved in mental health rehabilitation services who strive to improve the quality of life of persons with psychiatric disabilities.

**Thanks**
I would like to thank the National Institute for Health Policy Research that recognized the importance of the RMD law and the rehabilitation reform and decided to organize this workshop. As you are aware, in order for things to happen we need efficient, effective and committed administration. My gratitude to the staff of the NIHP and especially to Ziva Litvak that without her this workshop would not have taken place. Thanks also to the Israel National Council for the Rehabilitation in the Community of Persons with Mental Disabilities for the collaboration and support and to the steering committee of this Workshop. I greatly appreciate the support and active involvement in the Workshop of Alik Aviram, Yigaal Ginath and David Roe. Special thanks to Geula Altman who helped me with the logistics of the event and with the preparation of this book. Personally I would like to express my thanks and gratitude to all of them.

***Uri Aviram***
*Chairperson of the Workshop*

# Abstracts

# The Rehabilitation in the Community of Persons with Mental Disabilities Law of Israel: Challenge and Opportunity in a Changing Mental Health Service System

>> *Prof. Uri Aviram*

**Objectives** to assess the challenges and opportunity of the Israel Law for the Rehabilitation in the Community of Persons with Mental Disabilities (RMD) in affecting major changes in the system, and to review the risks that may hinder this law and its potential to contribute to a comprehensive mental health (MH) reform in Israel, transferring the locus of treatment and care to the community.

**Methods** included assessment of the MH rehabilitation arena and its functional environment, focusing on the critical elements of the MH service system, namely, clients, financial resources and personnel, and the principles governing their allocation and movement, as well as on the interest groups and issues related to the system.

**Findings** show that during the decade following the enactment of RMD law, enacted in 2000, there has been a remarkable increase in rehabilitation services and, related to the RMD law, a significant reduction in the number of psychiatric beds as well as major changes in budget allocations. However, ambulatory services suffered a set-back, and efforts to transfer MH services to general health-care providers has not been accomplished yet, endangering the success of the rehabilitation services.

**Discussion and conclusions** The changing nature of the target population as well as interest groups and major issues related to the functioning, monitoring and regulating a privatized rehabilitation services preset risks to the continued successful implementation of the RMD law and the quality of the MH system in general. Factors that endanger the viability of the RMD law and its role in bringing about a major MH reform are assessed. Conclusions on what may be necessary to protect the RMD law, and facilitate the required changes in the MH system are presented. Lessons from the Israeli experience that can be learned by other jurisdictions are discussed.

## Rehabilitation and Recovery: Evidence-based Practices

*>> Prof. Robert Drake*

Psychiatric rehabilitation addresses functional outcomes, such as independent living, working, and social relationships. Recovery emphasizes the individual's life goals. Evidence-based practices are interventions that have been proven to be effective in multiple contexts. This talk will provide an overview of five basic evidence-based practices that are commonly used to promote rehabilitation and recovery among people with serious mental illnesses in the U.S: illness management and recovery, integrated treatment for co-occurring disorders, assertive community treatment, family psychoeducation, and supported employment. I will describe each practice, summarize the research on each, and discuss some current areas of active model development and research.

Despite extensive research support, these five practices are not widely implemented and are in some ways controversial in the U.S. Some barriers regarding implementation are generic, for example, the lack of alignment with payment systems. Other barriers relate to specific practices. A few examples: Illness management and recovery requires clinicians to learn cognitive-behavioral treatment skills. Integrated dual diagnosis treatment requires clinicians to address addictions and to use addiction treatment interventions. Assertive community treatment was developed and validated during an era of extensive long-term hospitalization; its relevance for today's context is sometimes questioned. Family psychoeducation has research support but has never made the transition from efficacy to effectiveness. Supported employment conflicts with many established vocational paradigms, programs, and systems.

This talk will review these barriers and discuss current research strategies for refining interventions, addressing concerns, and implementing the interventions. In all cases current efforts are being considered in the context of President Obama's health care reform.



## Comments on Trends and Issues of Systems Integration in the U.S. and the U.K: Israeli Perspectives

*>> Prof. Yigal Ginat*

The two excellent presentations, on the British and the American experience illuminate most of the main issues of one of this Workshop's main themes – the integration of Community Rehabilitation Services for Persons with Psychiatric Disabilities with Health and Social Services.

The Israeli Law, as described by Prof. Aviram, states categorically that Rehabilitation is a Community-based Service. It is important to mention here that it was considered to be an act of a "Corrective Discrimination" nature, thus defining it as "exceptionalistic". On the other hand, Israel is heading now towards the "Third Revolution" in the Mental Health Care Delivery System, which includes transferring the responsibility of providing Inpatient and Outpatient Psychiatric services from the Ministry of Health to the "Sick Funds", thus integrating them or "Mainstreaming" them with general health services.

This, of course will increase the difficulty of coordinating Treatment and Rehabilitation. We observe here, in a way, two contradictory processes – one towards "mainstreaming" and one towards "exceptionalism". How can they coexist? How would they affect each other?

Coordination issues as well as competition also exist between the various professional groups who are involved in the developing of the Rehabilitation System. Personally, I feel sorry as most of my colleagues of the psychiatric profession take too little interest in rehabilitation.

In his presentation, Dr. Hogan emphasizes the structural aspect of the rehabilitation system in relation to other "neighboring" systems, whereas Prof. Thornicroft dedicates most of his presentation to the dynamics of the system's development in it's various stages – formulation (relating to what Prof. Aviram referred to as creating and preserving a coalition), implementation and consolidation, and how to navigate the boat avoiding the dangers such as budget cuts, etc.

The importance of "balanced care" is also very relevant to our discussion today. I mentioned just a few of the wealth of important issues presented by both Dr. Hogan and Prof. Thornicroft, and hope that these will serve as an "appetizer" for further discussion and analysis.



## Integrating Services for Recovery: Lessons from the American Experience

*>> Dr. Michael F. Hogan*

As mental health services move from hospital to community, the challenge of coordinating or integrating services becomes much more complex. Within the traditional psychiatric hospital, all services (for example housing, health care, psychiatric treatment and rehabilitation) are "under one roof" and under one authority. However, long term institutional care conflicts with the modern goal of community integration, and a fundamental principle of rehabilitation is that skills are best learned in the environment where they must be used. Therefore, community living is necessary for both legal/ethical reasons and because under the right conditions it is most effective for rehabilitation and recovery.

In communities, the many services and supports that might be needed by people with psychiatric disabilities may be provided by different authorities in different locations. Many services (e.g. housing, education, health care) may be delivered based on different conditions of eligibility. Integrating care becomes much more complex.

Morrissey and Goldman described "cycles of reform" in American mental health care. They assert that each reform movement in American mental health care (the asylum, the mental hygiene movement, the community mental health center, CMHC, approach and the community support concept) was aligned with a broader social and political reform. Except for the community support approach described by Turner and Ten Hoor, each earlier reform was associated with a type of facility (hospital, clinic, center). However, the community support approach envisions that people with serious mental illness would access many services in the larger community. Thus, the movement to community care makes integration of services more important and more difficult.

The problem of integration is possibly even more complicated in the U.S. than in other jurisdictions because the American governmental system is decentralized, with the federal government having broad responsibilities while states and local jurisdictions have considerable autonomy in what services are delivered, and how. Not surprisingly, broad assessments of mental health policy (such as by the two presidential Commissions to study

mental health) find the coordination of care – or in its absence, the problem of fragmentation – to be a major problem. Political scientists have gone so far as to suggest that the American distrust of central government and insistence on the separation and balancing of powers means that mental health care for those with the most serious mental illness in the U.S. will inevitably be flawed.

In this presentation I will illustrate some of these problems of fragmentation (e.g. as related to housing, health care and rehabilitation) and discuss emerging approaches to address the problem. In a recent review of America's progress in mental health, Frank and Glied conclude that the condition of people with mental illness compared with 50 years ago is "better but not well" (the title of their book). They also conclude that improvements are due more to a phenomenon of "integration" (better access to broad benefits like health insurance, social welfare and housing) than to strategies of "exceptionalism," such as improvements within the mental health field. Frank and Glied's assessment confirms the benefits of the community support idea but also underlies its practical difficulties. They propose a national office to take the lead on mental health policy as one solution.

The President's New Freedom Commission on Mental Health bemoaned the problem of fragmentation and offered several directions, including improved state government plans for mental health care, and better empowered services plans for individuals. A federal grant program to improve state coordination was launched, but its results are uncertain and have not been evaluated.

In disability services internationally, a theme of empowering individuals through collaborative and "person centered" planning is emerging. The question arises as to whether individual service plans can be an effective way to coordinate services and supports. At least in the U.S., person centered planning is better developed in the case of people with physical and intellectual disabilities – perhaps because many services to these individuals are funded as a personal care "package," creating a kind of personal budget that can be managed.

In mental health, the emerging paradigm of "recovery" alters perspectives on services and the problem of services coordination. While the original connotation of recovery was relief from symptoms, Anthony's seminal article borrows heavily from the influence of consumer leaders who see recovery as a personal process of adapting to illness/disability rather than an outcome



of services. This view of recovery is emerging as a major influence, although most services in the U.S. are funded by insurance programs such as Medicaid that emphasize treatment (and sometimes rehabilitation) rather than adaptation to illness/recovery.

A view of recovery as adaptation (in the words of the New Freedom Commission, "the process by which people live, work, learn and participate fully in the community") alters the challenge of services integration. This is doubly true considering Frank and Glied's finding that mainstream resources (which by definition, are provided by mainstream organizations) have been more crucial in the well-being of people with mental illness. I will provide examples of how the emerging recovery paradigm – coupled with mainstreaming of benefits – will alter needs for and patterns of service

# Comments on the Rehabilitation, Recovery, and Integration in the Community in the U.S. and the U.K: An Israeli Perspective

*>> Prof. David Roe*

In his opening talk, Uri Aviram emphasized the importance of learning from the vast amount of knowledge and experience gained elsewhere. The presentations by Bob Drake and Mike Slade provide an important opportunity for such learning. In my commentary I wish to briefly refer to five central issues which emerged from their talks which hold the potential to improve mental health service provision in Israel:

It may be time that Israel follows the action taken in several countries which and adapt recovery as part of its formal policy. While public declarations do not necessarily assure policy change, they certainly have the potential to guide and inspire such attempts.

1. Another worthwhile effort is to identify and disseminate Evidence Based Practices (EBP) while monitoring the degree to which they are implemented in a faithful manner and are effective in generating desirable outcomes. While there are some encouraging signs in Israel of efforts in this direction there is still a long way to go and much to be learned.

2. The importance of offering psychosocial interventions such as Supported Employment and Supported Education as close as possible to ones' first episode to prevent socializing people into disability is another important point. One of the major offices in Israel uses the term "LO BAR SHIKUM" (which in Hebrew means "Can't be rehabilitated") which ironically (and yet understandably) is quite desirable due to the incentives that accompany this label. Resources and incentives should be directed to help people live full lives despite disability and not become trapped by it.

3. Beyond specific interventions, the importance of focusing on the effectiveness of services in real world setting rather than their efficacy in isolated labs is emphasized.

4. Finally, the implications for the role of the mental health professional in the era of EBP and recovery require serious discussion, new conceptualizations and updated definitions. The education, training and supervision needs for the recovery oriented mental health professional who can faithfully provide EBPs and monitor outcomes poses important challenges to our educational system here in Israel which the time may be ripe to meet.

The international workshop with the contributions of our esteemed guests provides a rare opportunity to learn from others and take action towards advancing our efforts to improve our mental health system in Israel.

## The First Decade – Assessment and Dilemmas

*>> Yechiel Shereshevsky*

The Rehabilitation of Mentally Ill in the Community law enacted in 2000. Its main purpose was to enable mentally ill adults to live in the community, with an emphasis on quality of life with dignity while developing their strengths and fulfilling their aspirations.

**Clients:** The target population is individuals with a 40% disability due to major mental illness. Since 1997 more than 30,000 people have received rehabilitation services, and 16,000 persons are currently in the system. The rate of growth is 1200 consumers each year, which can be attributed to the limited number of clinics as well as insufficient awareness about rehabilitation. We hope that the reform in mental health will change this.

**Services:** The basket of services in the law, housing, vocational, social clubs, etc, are built in stages with the intention of providing clients the most appropriate services according to their needs and their level of functioning, and in the most normative setting possible. It is our intention that the services will improve based on accumulated experience and acquired knowledge, both in Israel and abroad.

It is clear that the existing services are successful in reducing hospitalizations and allowing individuals to live in the community. It is still unclear whether the services given are effective enough in giving individuals the tools to reach their maximum potential. We are currently developing tools to measure outcomes.

The law itself needed to be amended in order to include individuals that require more specialized service, e.g., substance abusers and persons suffering from organic disorders. .While the average age of the mental health consumer of rehabilitation services is 44, young consumers must have different services developed for their specific needs.

**Society:** Mental illness effects the essence of an individual's existence and is one of the basic reasons behind the stigma attached to it. This stigma creates barriers that prevents the full integration of individuals with mental illness into society. The actions needed to change this should be addressed to two fronts; consumers and their families and society in general. The most important tool is to create face-to-face interactions between mental health consumers and society at large.



## Understanding and supporting personal recovery

*>> Dr. Mike Slade*

Supporting personal recovery is a mental health policy goal in many countries. This policy is driven by an ideological orientation towards citizenship and social inclusion for people experiencing mental ill-health, and is in advance of the scientific evidence. This talk will describe new conceptual and implementation research. The first systematic review of personal recovery will be described, which identifies five components of many people's recovery journey: Connectedness, Hope, Identity, Meaning and purpose, and Empowerment. The Personal Recovery Framework will then be reported, which provides an evidence-based framework for mental health professionals to understand the processes involved in personal recovery. The Personal Recovery Framework identifies four ways in which services can support personal recovery: Fostering relationships, Promoting well-being, Offering treatments and Improving social inclusion. The implementation of these new approaches will be illustrated through international case studies of best practice.

The focus of the mental health system in the 1800s was on exclusion, and in the 1900s was on treatment. The emerging focus of international mental health systems for this century is on recovery. The consumer-developed idea of recovery now underpins mental health policy in many countries. Yet turning this recovery rhetoric into reality is a challenge. Personal recovery is different from clinical recovery. Key personal recovery domains are hope, identity, meaning and personal responsibility. If services are to fully support people with lived experience of mental illness in these and other domains of their recovery journey, then changes to current practices are needed. The distinction between traditional and recovery-focussed working will be identified, including in the areas of values, discourse and behaviour. A new empirically-based framework for understanding mental illness – the Personal Recovery Framework – will be presented, which gives primacy to personhood over illness. The recovery support tasks of a mental health worker in a recovery-focussed service will be identified, which will involve using many existing skills as well as developing new skills. This has implications for relationships, assessment processes, action planning, intervention strategies and risk management. These changes will be illustrated with international case studies.

## Integrating Rehabilitation Services for Persons with Psychiatric Disabilities with the Mental Health, Health, and Welfare Systems: Lessons from the Experience in England

*>> Prof. Graham Thornicroft*

First, the concept of balanced care is now replacing approaches which previously relied on hospital-based care or community-based care alone. Balanced care includes both modern community-based and modern hospital-based care. In balanced care the focus is upon services provided in normal community settings, as close to the population served as possible, and where admissions to hospital can be arranged promptly, but only when necessary.

Second, this presentation will also address how to resolve some of the frequently identified barriers to service improvement including: staff anxiety from uncertainty/threats, lack of structure in community services, how to initiate, initial opposition within the mental health system, opposition from neighbourhood, financial obstacles, system rigidity, boundaries and barriers, and maintaining morale.

Third the talk will consider some of the key overall lesson learned in developing community care including: that service changes need to take time, often developed over years and decades, after the initiation stage of change there is a need for a consolidation phase, listening to users' and to family members' experiences and perspectives, not allowing services changes to be used as an occasion for budget cuts, consolidating service changes with alterations to training curricula, and mental health laws and financial structures.

# Presentations

# The Rehabilitation in the Community of Persons with Mental Disabilities Law of Israel: Challenge and Opportunity in a Changing Mental Health Service System*

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## Introduction

On July 11th 2000, the Knesset (Israel's parliament) approved the Rehabilitation in the Community of Persons with Mental Disabilities Law (RMD)[1]. Ten years later, about 16,000 persons receive rehabilitation services in the community from more than 550 programs operating throughout the country. Since the implementation of this law was first budgeted in 2001, the government budget allocated for Mental Health (MH) rehabilitation services in the community increased (in constant money values) more than 8 fold, reaching about 125 million dollars per year, compared to a minute allocation of 10 million dollars a decade earlier. Furthermore, the proportion of rehabilitation services is now about 25% of the total MH government budget compared to 4% in the beginning of the decade. This budget allowed a dramatic change in the extent and variety of community services provided for persons suffering from mental disabilities, and in just one decade the number of persons receiving such services multiplied by a factor of four[2-6], (See Appendix Figures 1, 2, 3).

The RMD law is one of the most important social laws enacted in Israel, representing progressive approaches to the treatment and care of persons with mental disabilities[7]. The implementation of this law, defined as the Rehabilitation Reform, has been one of the major factors in bringing about important changes in the structure and processes of MH services in the country, and contributing to the country's efforts to shift the locus of treatment and care from mental institutions to the community[6,8]. One of

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these changes is the dramatic decline in the number of psychiatric beds in the country. Since the enactment of the RMD law, the rate of psychiatric beds in relation to the total population declined by 50%. Not surprisingly, during the same period, the changes were also reflected in a significant decline in the length of stay and a substantial reduction in the number of inpatients' days in psychiatric hospitals[2–5]. (See appendix, Figures 4, 5)

In this paper I would like to describe the principles of the RMD law and its innovative approach to the treatment and care of mentally disabled persons and to review important changes that have occurred in the MH service system in Israel since the enactment of the law. Following this, I will assess opportunities the RMD law has created and its potential contributions toward a comprehensive MH reform, as well as challenges and risks facing the system as the rehabilitation reform enters its second decade.

The methods used for the assessment are based on analyzing the domain of the MH rehabilitation arena and its functional environment, focusing on the critical elements of the MH service system, namely, clients, financial resources and personnel, and the principles governing their allocation and movement, as well as on the legislation and the interest groups and issues related to this system.

Although this paper describes mental health reform in a specific country, I believe that there are lessons to learn by other jurisdictions from the Israeli legislative approach at reforming the system as well as the discussion of the issues relating to its implementation and its continued success,

**The Rehabilitation of the Mentally Disabled in the Community Law.**
The basic tenets of the RMD law are the entitlement for rehabilitation and the provision of services based on defined eligible criteria and a professional assessment of need. As clearly stated in the law, its purpose was to strive for and advance the rehabilitation and integration of the mentally disabled in the community in order to allow them to achieve the maximum degree of functional independence and the highest possible quality of life, while preserving their dignity in the spirit of the Basic Law: Human Dignity and Liberty[1,9].

The provision of the law entitled every person, 18 years or older, who has medical disability of at least 40%, as established by the criteria and the regulations of the National Insurance Institute, accompanied by a professional opinion from a psychiatrist, to apply for psychiatric rehabilitation services.



The applicant can apply to a Regional Rehabilitation Committee, which is composed of three MH professional workers, and request rehabilitation services. Based on its professional assessment, this Committee may approve a package of rehabilitation services from a list of services determined by the Law. This package (or "basket" in Hebrew) includes services and programs as listed in the law: housing, employment, adult education, social and leisure time activity, assistance to families of the mentally disabled, dental care and case management.

The law established a National Council whose task has been to monitor the implementation of the law and advise the government how to further develop rehabilitation services for the mentally disabled. Another feature of the law is the clause requiring the executive branch to seek the approval of the legislature for any change in the package of services the government may want to introduce.

Following progressive approaches to rehabilitation[7,10,11], this law stated categorically that rehabilitation is a community based services, warding off the establishment of mental institutions to be included as eligible for rehabilitation funds allocated by this legislation By any international standards (e.g. 9), this law represents an innovative and progressive approach in the treatment, rehabilitation and care for persons suffering from mental disabilities. It reflects societal commitment to offer persons with serious mental illness rehabilitation services which can help improve their quality of life and facilitate their recovery process, though not necessarily curing them completely from their mental disorders or disabilities. It strives to mainstream and integrate these persons in the community in order to allow them to achieve the maximum degree of functional independence in spite of their disabilities while preserving their human rights and dignity.

## Changes, Opportunities and Risks

Admittedly, without the leadership, commitment and determination of the MK Tamar Goz'ansky and others, legislators, administrators, MH professionals, family members and users of services, who joined her, this law could not have been enacted. However, a configuration of factors, including a coalition of interest groups and specific circumstances allowed the efforts of the leadership that initiated and advocated for the law to bear fruits[6,12]. Had it been today, I doubt whether it would have been possible to achieve this legislation. This law was a private initiative of MK members submitted in spite

of the position of the executive branch. Since then, a special law was passed requiring government approval for any private legislative initiative that has major financial commitment and implications[13].

One of the factors that might have facilitated the rehabilitation reform was the fact that the reform was financed by new money allotted by the MOF. In spite of the dramatic reduction in the number of psychiatric beds and the number of inpatients' days, the budget of government mental hospitals was not reduced (in constant prices) nor even one government psychiatric hospital was closed[2,3,6] This might have been the reason why the strong interest group of government psychiatric hospitals supported the changes (See Appendix, Figure 6).

Another important factor in the success of the RMD law was the fact that the Ministry of Finance (MOF) supported it and decided to budget its implementation[14]. Had it not been the case, this law could have remained a fine legislation on the books with no real effect on the system. During the process of legislation, the MOF tried to prevent the legislation of the RMD law, due to its concern for uncontrolled and unpredictable financial demands, and only when realized that it could not be stopped the Treasury decided to join the coalition that supported the law. However, the MOF agreed to support the law only after reaching an agreement with the Ministry of Health for a massive reduction in the number of psychiatric beds[6,12]. Later, the MOF, still concerned from the lack of a financial cap on the demands for entitled rehabilitation services, will try to change the RMD law[15].

As in so many other legislative processes, the coalition that supported the RMD law could be defined as an "unholy alliance", in which members of the coalition supported the law with different objectives in mind, emphasizing different points and not necessarily expecting similar outcomes as a result of the implementation of the law. Whereas, no doubt, some wanted to improve services, to better the rights and quality of life of mentally disabled persons, there were others that put an emphasis on reducing the use of inpatient psychiatric beds, decreasing the number of state employees and saving state's expenditures.

Once a law is passed and implemented, and the circumstances change, often the coalition that supported the law is weakened or might even completely dissolve. Fortunately, in the case of the RMD law, several members of the



original coalition continue to be firm supporters of the law. However, some have changed their priorities. As mentioned earlier, the MOF concerned to lose control over the expenditures due to services demand from entitled persons, has been trying to change the RMD. This Ministry conditioned its support of the proposed MH reform, transferring the responsibility for providing MH inpatient and ambulatory services to the heath care **provider** organizations, on including "rider" legislation (section 12 in the MH reform law), and changing the RMD law[16]. If indeed the Knesset accepts this proposed change, it will be a major blow to the RMD law, restricting, in fact, the entitlement principle of this legislation.

In the debate over the budgetary ramifications of the rehabilitation reform the MOF emphasized the fact that the rehabilitation reform was financed without reducing the inpatient services budgets. The officials of the MOH and MOF claim that this was due to the fact that psychiatric hospitals have been under budget. Hardly anyone could have contested this claim.

However, in the debate over the budgets of the rehabilitation services we should not neglect to mention that if indeed the number of psychiatric beds had not been substantially declined, the costs for inpatient services would have been much higher. Between 1999 and 2009, the total number of inpatient days that were saved compared to the 1998 level was 912,127[3,4] which over a period of a decade translates into saving over 1billion NIS (about 275 million dollars) beyond the amount spent on rehabilitation services. Since, in my opinion, the decline in the number of inpatient days could not have happened without the rehabilitation reform, policy makers should be reminded these facts when considering the future plans of the mental health services.

The MOF changed position is just one example of dwindling supports for the rehabilitation reform among some who had earlier supported the law. There are other interest groups that might have changed their positions. The major interest groups are those that are in the task environment of the MH rehabilitation system, those organizations and groups that may affect the input and output of the rehabilitation system[17]. These may include the psychiatric hospitals, the community MH clinics, the health care providing organizations, the State's ministries that are involved directly or indirectly with services to persons with psychiatric disabilities, as well as the families of the disabled and the users of the services. The leadership of the

rehabilitation reform and its current administration must be aware of such changes, and should invest efforts in maintaining the coalition and strengthening it both politically and publicly.

## Maturation of the service system and needed organizational adaptation

As the rehabilitation service system enters its second decade, it must **undertake** organizational changes. The first generation of leaders, who had to implement the law and to develop a new service system, had to be creative, innovative, move fast, and at times, not having a tradition and any previous organizational arrangements, even to "cut corners" .. In a relatively short period of time the system has grown dramatically. From an almost a one **person's** operation it has become a state wide agency managing hundreds of services throughout the country, all of which are not-for profit agencies or private, for profit service providers. All these require major organizational changes.

**Recent** annual report of the Comptroller General and the Israel National Council for the Rehabilitation in the Community of Persons with Mental Disabilities (hence fore, the Council)[18,19] illuminates some of the areas requiring changes. These include an accurate data base system, beefing up the headquarters' personnel, increasing the monitoring and control system, conducting periodic follow up services, expanding case management services, developing up-to-date regulations, adequately responding to special demands of peripheral communities such as those in rural areas and places far from the population centers and adapting rehabilitation services to the changing nature of the target population as well as to persons with special needs such as dual diagnoses.

The rehabilitation service system will have to respond to demands to measure the effectiveness and efficiency of its services and to provide evidence to its task environment of its successes in its rehabilitation efforts. Such demands to show results began already a few years ago by the MOF and the Planning and Budgeting Department of the MOH. Undoubtedly sooner or later the rehabilitation system, in order to protect or even strengthen its legitimacy, will have to study its operations and programs and provide evidence for its societal contribution. This is not a simple task. Criteria for success have not yet been well developed, variables that should be measured are not agreed upon, quite a few of the intervention modes follow latest fads rather than being



based on evidence-based practice, and finally, there is no consensus among MH professionals as well as other interested parties what are the criteria for success and how to measure progress or failure.

In spite of all the difficulties, the rehabilitation service system will have to meet the challenge. It should devote much thought and resources to developing research system to describe the service system, assess its operation and evaluate its outcomes. It should not limit its studies to traditional criteria looking at how many hospitalization days it has saved, or even not only to the improvements achieved in the quality of lives of the recipients of services, though by no-means should such studies be neglected, but also to issues of social and economic benefits to society as a result of rehabilitation, such as free market employment.

Needless to mention that on these matters Israel should not attempt to solely rely on knowledge and experience gained in this country alone. It must use the vast amount of knowledge and experience gained elsewhere. One possible approach may be a development of a clearing house that would accumulate, assess and distribute knowledge and evidence based programs from other countries. Another important and rather urgent task for the rehabilitation system is to develop a survey and research program. Whereas priorities should be determined by the administration of the rehabilitation services and the Ministry of Health, the research should be completely independent of the administration of the service. Furthermore, as has already been suggested by the Council, a special effort, using scholarship programs and grants, should be made to improve the quality of researchers in the field of rehabilitation [19].

## Population served, financial supports, personnel and services rendered

By any measure, the rehabilitation services established in Israel in only one decade are a remarkable achievement. However, there are quite a few challenges faced by the system and many changes are needed. The number of persons served is only about 15-20% of the estimated number of the eligible population[6,20]. Even if only one half of this group would be of need or apply for services, they would comprise a very large increase. Furthermore, many of those who are not yet in the system of care represent more difficult population groups. It will not be a simple matter to reach out and identify

those, refer them for assessment, develop appropriate packages of services, and last but not least, raise the finances needed for those services.

Another pressing task of the rehabilitation system is to understand why many of the mentally disabled do not actually use the package of rehabilitation services that had been approved for them. Data shows that 25–30% never utilizes even one service of the package. Many more do not use parts of the packages approved for them[2,3,20,21]. So far, we do not know much on the nature of the problem, its distribution by demographic or geographical variables nor do we know any of the reasons for this underuse or decline to use the approved packages.

Expanding the services for the eligible, not yet being served, population, as well as improving the effectiveness and quality of services will require additional financial resources. These should be more than the average that has been allocated so far.

Whereas for the first five years the MOF and the MOH agreed on a plan for an annual increase of the budget for rehabilitation services, no such plan has existed since 2005. Although there have been annual increases of the budgets they have not been based on a long range plan, taking into account such variables as the changing nature of the population or adapting cost of services to the different regions of the country.

A pending plan, that for years has been awaiting implementation until after the MH insurance reform would be approved, is based on the assumption that the steady state of the rehabilitation system would be 22,000 persons. This figure was based on an annual increase of 1,200 persons per year for only 5 years[21]. The only rationale provided was that this number represented the average annual increase of the first five years since the beginning of the rehabilitation reform. This is a poor approach for long term planning; many variables could have been responsible for the average annual numbers. Furthermore, the assumption of the total number at steady state neither is far below the above mentioned estimates nor was it based on any reliable data or study of the size of the eligible population[20,22].

Admittedly, the increase of the government budgets for the MH rehabilitation services during the last decade is impressive. However, the fact that the number of mentally disabled persons receiving services has not grown faster, might be related to limited budgets that do not allow better reaching



out services, larger staff and adaptation of types and nature of services to special population and outlying areas. Furthermore, assessing the allocations for rehabilitation services shows that if an annual increase of 1,200 persons of those yet **unserved**, adjusting for inflation as well as the growth of the country's general population, the per capita budget for the rehabilitation services would have actually declined by close to 20% (from 23,300 NIS per capita in 2005 to 19,200 NIS in 2010), (See figure). The actual per capita budget allocations remained about the same during this period due to the fact that the number of recipients has not grown as expected.

Although analysis of needed and adequate financial resources for the rehabilitation services for the next decade requires more studies, there are three more points regarding the budget that I would like to make at this time. If indeed efforts to pass the legislation for the MH insurance reform (16) are successful, expected ambulatory community services improve, more hospitalizations are prevented, and the length of hospital stays is shortened, it is expected that demands for rehabilitation for the mentally disabled in the community would be increased. I wonder whether MH service planners have been preparing for this increased demand for services.

Another concern is also related to the planned insurance reform[16]. Once the responsibility for the clinical MH services, i.e., inpatient and ambulatory community services is transferred to the healthcare organizations, due to a variety of reasons these organizations may prefer the so called "soft" psychiatric cases, and neglect the severely mentally ill. Since the mental health service components are interdependent, undoubtedly that if this happens, rehabilitation services would be adversely affected.

Another potential negative outcome of the planned insurance reform is related to the fact that budgets that would be transferred to the health care providers would not be earmarked for psychiatric services. If left to the discretion of these organizations, pressures by other medical specialties and other interests may lead to MH funds being transferred to other purposes. A decline in financial resources for MH services, would reduce scope and quality of services and, as already mentioned, since the components of MH services are interdependent, rehabilitation services may be badly hurt.

Closely related to both, budgetary and organizational matters are issues connected to personnel considerations. These relate to size and quality of personnel, tasks and professional training. The system has grown very

quickly yet the number of headquarters personnel has not followed suit. The State's Comptroller General has also mentioned this matter in his reports (18). The fact that service delivery is completely privatized requires urgent solutions to regulatory matters. However, the number of personnel involved in monitoring and control is far from being sufficient[6,18].

Perhaps one of the most problematic issues related to the fact that the delivery of services is based on the private market, is the danger that government might become captive of the organizations that provide services. A situation of market failure might develop. The idea was that market competition would lead to improvement of services and saving of resources. However, since the government tries to control (or even reduce) costs, hardly any competition exists. Some of the service providers, in order to cut expenses, even resort to "cutting corners". Government is limited in its power to sanction these providers, because, in view of the stingy contracts, no other providers are available, yet services are needed. Thus, the government, instead of controlling and regulating the service providers, becomes a captive of them.

Privatization of the services and efforts to save money are affecting the quality of personnel employed by these services. In an effort to save money, operators of services have a strong incentive to hire low level personnel and do not provide adequate on-the-job training. The government, in its efforts to reduce costs, refrains from tough contracts demanding high level personnel. This situation affects the quality of services provided for the persons in the various rehabilitation programs.

As Israel has reached the end of the first decade of the rehabilitation reform, the package of services should be assessed. Perhaps some services are no longer needed, or others should be added. We do not know whether services have been effective and efficient. Unfortunately, a data base has not been well developed, nor have enough and adequate studies been conducted about the process and outcome of services. It is imperative to develop a system that would finance and facilitate research on the rehabilitation services. I suggest that either through legislation or administrative decision, a special appropriation of money will be devoted for research and knowledge development, and organizational arrangements be set up to execute research and evaluation of the system. Although the input of the executive branch is essential for deciding on the priorities for research and evaluation, assessing the quality of the research proposals and awarding research grants should be completely independent of the administration of the services.



## Conclusion

We could continue mentioning more issues faced by the system as it enters its second decade. Time and space does not allow expanding on these matters. It is important to remember that the achievements of the first decade are not an assurance for success in the second decade of the rehabilitation reform. We need to assess the system and correct what is necessary and what we can.

True, not all is in our hands to change, nor can we anticipate in full the future and plan accordingly. The changing environment and the unpredictable circumstances, especially in view of the turbulent environment in which Israel is located, require us to establish flexible organizational arrangements that would be sensitive to changes and make the necessary adaptations.

Since the target population of the rehabilitation system is rather a weak one, lacks political power and is quite often excluded and stigmatized, our professional and moral responsibility is to not rely solely on our knowledge and professional expertise, but also to organize – together with users of services and their families as well as other stakeholders and concerned citizens – political and public lobbies to advocate for the cause of the mentally disabled persons.

No doubt that the MH rehabilitation reform has been an important change in the MH services in Israel, and is in fact a source of pride for those of us who have been involved in it and for Israel in general. Furthermore, I believe that there are lessons to learn for other jurisdictions from the Israeli legislations and the issues related to its implementation.

As shown, the continued success of the Israeli rehabilitation reform is not assured. Admittedly, many of the problems are beyond our control. Their solution is dependent on other government agencies or on society in general. Not enough knowledge is available and much is not known nor even anticipated or predicted. However, much can be done and should be done if indeed we want to preserve the reform, further develop the services and improve the quality of lives of mentally disabled persons.

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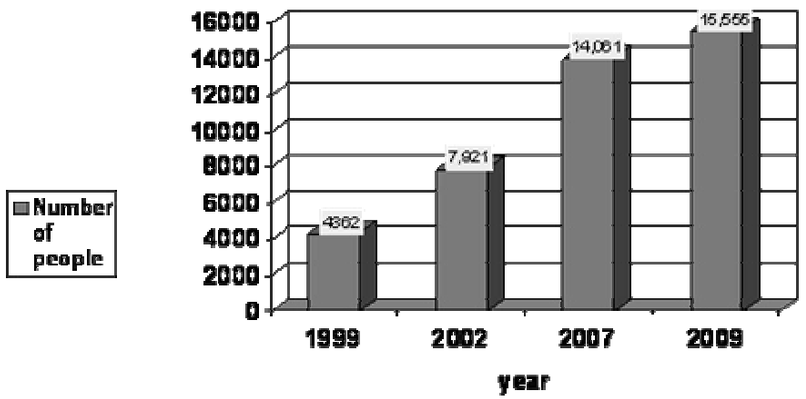
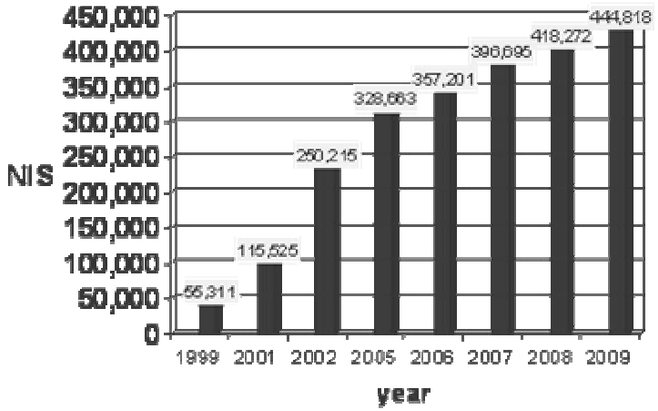
## Appendix

**Figure 1:** Number of persons in rehabilitation services in the community, 1999–2009




Source: Ministry of Health, Department of Information and Evaluation

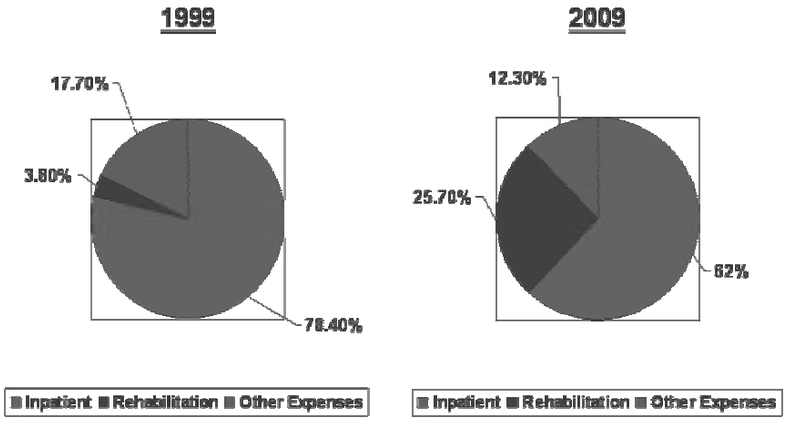
**Figure 2:** Increase in rehabilitation services budget*, 2000–2009




* Budgets include changes during the year.
Constant prices based on the health index of 2009.
Source: State Budget, 1999-2009 and Department of Planning and Budgeting, Ministry of Health.

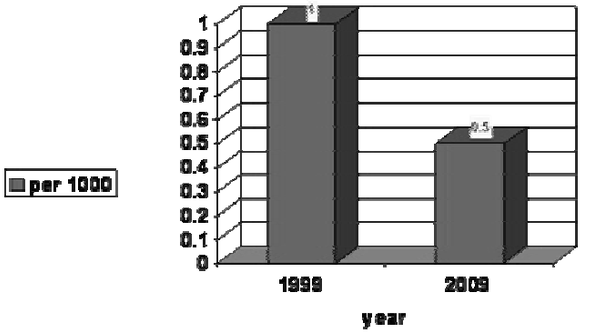


**Figure 3:** Budget distribution for mental health services 1999–2009*



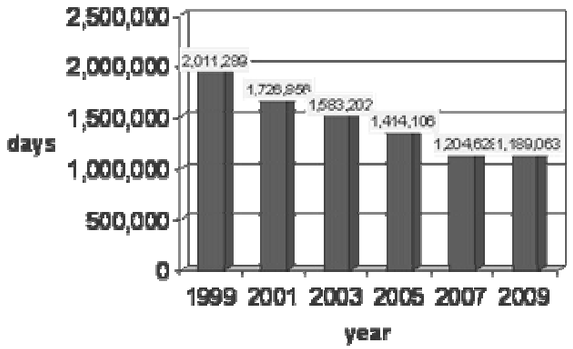

* Budgets include changes during the year.
Source: State Budget years 1999-2009

**Figure 4:** Rates of psychiatric hospitalizations per 1000 people, 1999–2009



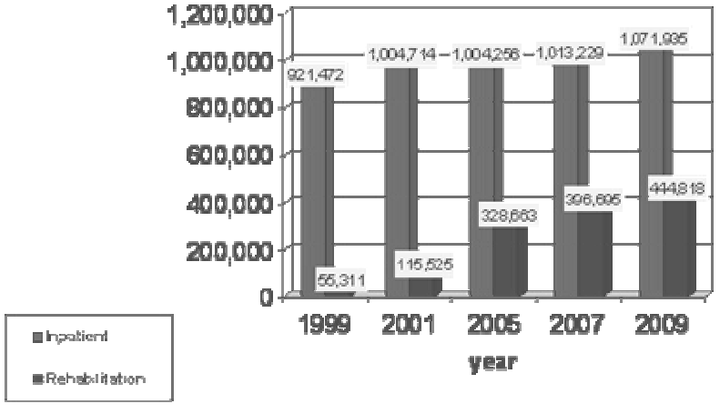

Source: Central Bureau of Statistics, Statistical Annuals, 2000, 2010 and personal communication, Department of Information and Evaluation, Ministry of Health.

**Figure 5:** Decline in the number of inpatient days in psychiatric institutions throughout the year, 1999–2009




Source :Inpatient Institutions and Day care units in Israel.
Department of Health Information, Ministry of Health.

**Figure 6:** Budget for mental health services: inpatients* and rehabilitation in the community, 1999–2009**




* Inpatients include: psychiatric hospitals, acquisitions from hospitals, and acquisitions of hospitalization substitutes.

** In thousands of NIS, constant prices based on the health index of 2009.

Source: State Budgets, 1999-2009, , and Department for Planning and Budgeting, Ministry of Health .



# Rehabilitation of Persons with Mental Disabilities in Israel: The First Decade – Assessment and Dillemas*

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## Introduction

The intention of the law is to help mentally disabled people to integrate in the community with dignity, and to improve their quality of life. The services developed by the Government, cover almost all areas of life, and clients can get as much services as they need, according to a professional committee's decision. The committee meets the client, his family, his therapist and everyone concerns.

## Clients

The law gives rights to adults (above 18) who have at least 40% disability, caused by mental problems, according to the criterion of the National Insurance Institute. Most of them suffer from major mental illness like schizophrenia or affective illness.

We know that there are many young people, under 18 years old, who could be helped by the services, and we hope that in the future they will be included in the law.

We hope that in the future the law will also include people with less than 40% disability, who need major help to integrate into the community, and can benefit a lot from the rehab. services. I believe that we must find a better criterion than the 40%.

From 1997 until now, about 30,000 people received services from the rehab. system, and at the moment about 16,000 are receiving services. There are some

* Presentation at the International Workshop, Rehabilitation and Community Integration of Persons with Psychiatric Disabilities: The Fitst Ten Years and Beyond, The Israel National Institute for Health Policy Research, October 13–14, 2010.

reasons for the difference between the two numbers. Some people are sent into the system by their family or therapist and not by their own will. Many of them are failing and going back home or even to the hospital. Some people are leaving the rehab. system after they become fully independent and feel they don't need the services anymore. Several hundreds died (many entered the system at an old age). Some went to old age homes and some failed and went back to hospitals.

The number of people, who get permanent services, increases by 1,200 a year on an average, which is less than we expected.

I think that there are many people who suffer from mental illness, who can get along quite well without our help.

There are others who can benefit from our services, but don't ask for help, because of the stigma, just like those who don't ask for therapy. And there are those who prefer to have no connection with the establishment, and of course they have the right to live as they choose.

I believe that the number of potential clients is 30,000–40,000.
Prof. Aviram raised the problem that about 35% of the people that were entitled by the committee to get services do not show up to get the services at all. But if we keep close look for a whole year, and not only 3 months, we find it's only 20% that do not use the services.

The reasons why those 20% do not show up to get their services are:

- The clients were not yet ready.
- Some clients experienced mental crisis.
- Some clients needed professional help to reach the services and couldn't get it, not from the hospital nor from the ambulatory clinic.

I would like to mention here, that in the last 2 years, there is a new service of case management in the center of Israel, and we can see that many more people use the system in this area.

I believe that after the health care provider organizations will take responsibility for mental health services, according to the reform planned by the Government, they will have an interest to bring as many people as they can to use the rehab. system.



One of the targets of the reform is to have many more units of ambulatory services, in comparison to present time. Therefore many more clients will be referred to the rehab committees and will get help to get to their units.

Another consequence of the reform is that professional staff of the rehab. units will concentrate on the rehab. work instead of using a lot of time for psychotherapy as they do now, because there are not enough clinics in the country.

It is very important to refer to young people in first hospitalization. Most of them don't think that they are really ill. They prefer to look on the hospitalization as an episodical crisis and not as an illness. Therefore they don't want rehab. help and even the staff who treats them, hesitate to refer them to rehab. We still fail to diagnose who will suffer from more crises and who is part of the third (33%) who will spontaneously recover, and it's better for them not to arrive to the rehab system. This is indeed a very serious problem.

For helping young people we must find a way with as little stigmatization as we can. Perhaps we have to bypass the assessment of disability required by the national insurance, perhaps even bypass our own bureaucracy. We must find ways to help them in the normative academic world, in the normative working world and maybe even in the army; with normative ways.

## The services

The services were built with an intention to cover all basic needs of life. But of course there are limits to every basket. Now is the time to broaden the basket and add services for those who need more. There are people with very serious behavior problems. There are many people with all kind of dual or even triple diagnosis. We need to have special units for these people with larger staff, and much bigger budget.

We have to remember that hospitals don't like to treat these difficult people, and their families suffer a great deal when they live at home.

Last point, we hope that with the right and sufficient staff, they can improve.

## Treatment plans and recovery

We would like all staff members to be able to create with each client an individual rehab plan fitting his special needs. The client has to feel that he takes a real part in building the plan.

Recovery is now the hot topic in the field. I think we should be careful not to reach extreme concepts. On one side, we can be too close to the anti-psychiatric movement and to idealization of the mentally ill. On the other hand, we should be aware not to patronize or devaluate the clients.

If the will of the client will be the only criterion we take into account, there is a possibility that he will fail. If we would have followed their desire, almost 90% of long-term hospitalized clients would have stayed in hospitals till now, even though now 99% thank us for releasing them to the community.

Another issue I would like to point out is that many people don't have a clear vision for their future. I believe that even between us in this room, there is more than one who would fit this description.

We should help clients reveal and develop their will. The opinion that we can find in text books that a part of the syndrome of schizophrenia is lack of motivation, is a myth. I believe that even you and I will lose any hope after being in hospital for decades, hearing messages like: you can't judge, you can't take responsibility, your illness is chronic, you can't trust your mind, etc.

We were witnesses to many people who changed very fast after leaving the hospital and joining a rehab system. It was amazing to see how hospital staff couldn't recognize their patients when they visited them after one month of rehabilitation.

Even though there are situations where we must make decision for them, we can do it only when we are sure that it is the best and they will appreciate it with time. But I need to emphasize again that we must be very careful to prevent imposing our values and aspiration on the clients.

Many staff members believe that the Ministry expects them to push all the clients all the time to a higher level of functioning. We need to persuade them to be more sensitive to the will of the client and to know how to introduce clients to options, but at the same time – to respect them if they choose a certain life style without challenges.



Another point which refers to the independence of the clients and to their personal wishes is the possibility of giving them an option to create their own personal rehab plan by themselves, and finance the process to fulfill it.

This way will be, of course, with a limited sum of money and with a very close supervision, but can open a very interesting and efficient rehab. direction. It might be difficult to overcome the bureaucracy of the Government, but I hope that we will succeed.

## Society

The main problem of people who suffer from mental illness, is how society relates to them. I'm not sure that this is not a bigger problem than illness itself. I believe that without the stigma, illness could be only some short episodes. I believe that if we shall overcome the stigma, we could significantly reduce the rehab. services.

The main road to defuse the stigma is to bring both sides together. We have experienced strong opposition by neighbors whenever we opened new facilities, but in 99% of the cases, after a period of time, relationship significantly improved. In many places, the neighbors visit the unit's residences and let their children do the same. There are also some cases where the residents were invited to visit homes of neighbors.

One of the serious problems is the stigma that clients have about themselves. We have to remember that they were growing up in the general society, and they had absorbed the same prejudices. They are aware what people think about them, and many times they share it and have the same opinion about people with mental illness, and have very low self-image.

We have to invest seriously in the struggle against stigma. We had already conducted several workshops dealing with self-stigma. There is some activity among mental health professionals even in the rehab. field. There is an organization of people who cope themselves with their illness, who meet with students, professionals and other people, to tell their own story and to attempt to change the opinion about mental illness.
All what I have described above is only the beginning of a very long road, but we never lose hope.

# Integrating Services for Recovery: Lessons from the American Experience*

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## Introduction

As mental health services moved from hospital to community, the challenge of coordinating or integrating services became much more complex. Within the traditional psychiatric hospital, all services (for example health care, housing, psychiatric treatment and rehabilitation) were "under one roof" and under one authority. Coordinating care was relatively easy. However, the convenience of managing care within an institution does not justify keeping people there if they are able to live in a community. The modern view is that long term institutional care–except perhaps for a very small number of people with profound disorders who cannot live safely without total care – is inappropriate. As in the case of other medical illnesses, brief hospitalization can be useful to stabilize or correct an intensive illness. On the other hand, living in a hospital restricts human rights and conflicts with the modern ethic of community integration.

Expressed in different ways in different countries and cultures, the goal of community integration is illustrated in the Israel Rehabilitation Act[1] In Britain, a recent report describes progress toward "social inclusion"[2] In the United States, President George Bush's Executive Order establishing The President's New Freedom Commission on Mental Health indicated "The Commission's goal shall be to recommend improvements to enable adults with serious mental illness and children with serious emotional disturbances to live, work, learn, and participate fully in their communities[3] . .Thus, the goal of community living is becoming well established for ethical reasons.

There are also clinical reasons why community treatment is preferable whenever possible. The everyday independent living skills of community life

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tend to be eroded over time when people are "taken care of" in a hospital. Learning and rehabilitation theory also suggests that skills are best taught and learned in the environment where they must be used, because generalization of learning is facilitated.

Community living, treatment and rehabilitation are preferred over institutional care for legal, ethical and clinical reasons. However, coordination of services is much more complex in the community. Services are no longer under one roof, or even under one authority. Care must be individualized yet individual needs vary widely. Indeed, in the case of people with serious mental illness, the needs of individuals and the services they use vary widely from time to time[4].

In communities, services and supports for people with psychiatric disabilities may be provided by different authorities in different locations. Many services (e.g. housing, education, health care) have different eligibility requirements based on income, disability status, or other requirements. Meeting the needs of people living in dispersed locations who may need many different supports from different agencies is no small task. In the U.S., discussions of integrating care generally followed, rather than led, the move to community care. U.S. legislation encouraging community care (e.g. President Kennedy's Community Mental Health Centers Act of 1963) was followed by federal initiatives on "services integration." Coordination of care was the focus of some programs (e.g. case management) and was "built into" others like Assertive Community Treatment with its focus on treatment, rehabilitation and care coordination[5]. In the U.S., coordination of care has generally been a policy afterthought. Coordination has perhaps been discussed more frequently via criticism of services arrangements ("falling through the cracks") than as a theme in planning community care. The problem of coordinating care has never been solved. In fact, the more complex community care becomes, the more challenging coordination is.

Morrissey and Goldman[6] described "cycles of reform" in American mental health care. They assert that each reform movement in American mental health care (the asylum, the mental hygiene movement, community mental health centers and the community support concept) was aligned with a broader social and political reform. Except for the community support approach described by Turner and Ten Hoor[7], each reform was also associated with a type of facility (hospital, clinic, center).

The community support concept went beyond decentralization of services, emphasizing that people with serious mental illness would not only use community mental health treatment but would live in ordinary community settings and access services located throughout and used by the larger community. Thus, the move beyond community care to an emphasis on community living made integration of services even more important and more difficult.

In this paper I will argue that structural and organizational "solutions" for care coordination cannot be fully achieved, at least in the U. S. I will also argue that the "recovery" paradigm creates new opportunities to improve care coordination.

## The overall well-being of people with mental illness in the U.S.

In a recent review of America's progress in mental health, Frank and Glied[8] conclude that the condition of people with mental illness compared with 50 years ago is "better but not well." Reviewing the forces that have produced change, they conclude that progress is due more to "mainstreaming" (better access for people with mental illness to broad benefits like health insurance, social welfare and housing) than to a strategy of "exceptionalism" (improvements within the mental health field, such as better treatment). Table 1 below illustrates mainstream improvements that have benefitted those with mental illness.

**Table 1:** Resources received by persons with severe and persistent mental illness in the U.S. (from Frank and Glied 8)

| 1972 | 1998 |
|---|---|
| 31% receive food stamps | 63% receive food stamps |
| 33% on Medicaid | 60% on Medicaid |
| No Supplemental Security Income (SSI) | 41% receive SSI |
| 7% receive Social Security Disability Income (SSDI) | 30% receive SSDI |
| No housing voucher program ("section 8") | 4% have federal housing voucher |



Frank and Glied's assessment confirms that the theoretical benefits of the community support concept have in part been achieved. Many individuals with mental illness have been able to access benefits and services in the larger community, rather than relying on a specialty mental health system to meet these needs. However, progress has been incomplete at best. The familiar refrain that consumers "fall through the cracks" sums up the problem; examples are many, and tragic. People with mental illness are about half of the chronically homeless population, are overrepresented in jails and prisons and have the lowest success rate in obtaining employment of any disability group.

Of course, the reasons for these failures are diverse and complex. They include: 1) an inadequate supply of the resources people need to live in the community (e.g. insufficient affordable housing and available housing subsidies[9]. 2) a poor "fit" of services to needs (e.g. the traditional model of vocational rehabilitation is not very helpful to people with serious mental illness) and 3) problems in integrating/coordinating services (e.g. the failure of mental health and law enforcement programs to work together).

It is perhaps impossible to fully isolate these problems or to solve them in isolation. As to the basic supply of services, America's ambivalence about providing social insurance and social welfare services compared to other Western democracies is well known, and reflected in the recent bruising political battle to extend health insurance coverage. There is no national family subsidy or universal early childhood education program in the U.S. There is no substantial national program regarding services for people with serious mental illness, and approaches vary widely between states.

## The problem of services coordination/integration of care in the U.S.

The problem of integration is possibly even more complicated in the U.S. than in other jurisdictions because the American governmental system is decentralized – both politically and organizationally. The federal government has broad responsibility for health and social services but states and local jurisdictions have considerable autonomy in what services are delivered, and how. Medicaid – the health and long term care program for elderly, poor and disabled individuals and the largest payer for mental health care in the U.S. – is a good example. It is a national program administered in partnership with states, which have considerable latitude in terms of eligibility, covered services

and administration. Services such as residential treatment facilities (RTF's) for children and Assertive Community Treatment (ACT) teams for adults are optional services covered by some states but not others. The national social insurance program for individuals with disabilities (Supplemental Security Income) has a minimum monthly benefit (in 2010, $674 monthly for individuals living alone) but states may add to the benefit levels. Many states add special payments for people residing in residential programs, to help offset the costs of these programs.

There is also great variability among states in the U.S. (e.g. geographic and population size, population density, racial diversity). The organization of mental health care – which historically has been primarily a state responsibility – is also variable. The state mental health authority may be a Cabinet level agency devoted solely to mental health care in which the director reports to the Governor. Or the mental health authority may be an office or bureau of a larger health or social services agency. The agency may be responsible only for mental health programs, or may also administer alcohol and drug addiction services and programs for those with intellectual disabilities. At the community level, there is no uniform framework for organizing care; mental health services in communities may be coordinated by local government (e.g. cities, counties), by local authorities, or by NGO's under delegated state authority. And at both, the state and local/regional level, services and supports needed by individuals with mental illness (e.g. mental health treatment, health care, education, rehabilitation, health care) are likely to be administered by distinct agencies.

Not surprisingly, given this context, broad assessments of mental health policy (such as by the two Commissions appointed by Presidents Carter and Bush to study mental health care) find the coordination of care – or in its absence, the problem of fragmentation – to be a major problem. Political scientists have gone so far as to suggest that the American distrust of central government and insistence on the separation and balancing of powers means that mental health care for those with the most serious mental illness in the U.S. will inevitably be flawed. Marmor and Gill[10] noted the challenge of meeting the needs of people with serious mental illness (requiring well-coordinated approaches across jurisdictions and agencies) in the U.S., where politics are incremental and the massing of power/control is resisted by the political process.



Methods of coordinating services are diverse. For example, Hogan and MacEachron[11] identified 29 strategies. They suggest that multiple strategies are necessary to achieve "empowered coordination," defined as "publicly sanctioned power sufficient to establish overall goals within a system, allocate resources according to those goals, and manage services to assure goals are achieved" (p. 18).

It is easier to criticize the lack of integration or to discuss the coordination problem theoretically than it is to solve it. Challenges in services coordination are complex, dynamic and elusive; there is no single or simple solution. Furthermore, the geographic, political, organizational and clinical contexts of care affect coordination challenges and solutions. Integrating care within an organization is one thing while coordination across organizations is more complex; coordinating a single kind of service e.g. transportation is much less than coordinating multiple categories of services and supports. Coordinating care in rural areas presents different challenges than in small cities, and the complexity of arrangements is greatly increased in major metropolitan areas.

How services and supports are financed also shapes coordination challenges. For example, many services to individuals with intellectual disabilities in the U.S. are financed under a program that provides individual alternatives to institutional placement under a personal plan of community care that may include residential care, habilitation and other supports. For individuals or families who can obtain these services, integration of care is driven by the individual's plan of care. However, because there is no such mechanism providing care for individuals with serious mental illness, fragmented care is typical. This is not intentional but "accidental policy;" since institutional care is not provided to people with mental illness in the Medicaid program, individual packages of community alternatives are not available. Rather, services and supports for people with mental illness (e.g. mental health treatment, health care, housing, rehabilitation) are typically provided by different programs at different locations. There is little wonder that coordinating care is much more difficult.

The problem of coordinating/integrating mental health services has been much discussed in the U.S., but seldom accomplished on a large scale. Grob and Goldman[12] point out that fragmentation of services was a theme addressed by both presidential mental health commissions. Coordinating care was a major objective of the Robert Wood Johnson Foundation Program on

Chronic Mental illness[13], which sought to create a single authority to coordinate care in each of nine major American cities. The program was implemented successfully, but the evaluation revealed that changes in system structure (to improve coordination) did not lead to improvements in client outcomes[14]. More recently, the President's New Freedom Commission on Mental Health[15] bemoaned the problem of fragmentation and offered several recommendations. These included a proposal for improved state government plans for mental health care, and better empowered services plans for individuals. Members of the Commission discussed proposals to elevate federal responsibility for mental health care, but were dissuaded by Bush Administration officials from making such recommendations. Instead, a federal grant program to improve state mental health services policy and coordination was launched, but its results are uncertain and have not yet been evaluated. Frank and Glied[8] proposed a national office to take the lead on mental health policy, citing a presidential office created to improve coordination of drug policy. However, no action on this proposal seems to be planned at the current time.

## Prospects for improving mental health care coordination

Strategies for services integration or coordination may be executed at the community, program or client level – although action at the national or state levels may be needed to provide the tools for coordination. As Marmor and Gill [10] noted, broad and consistent federal and state approaches to mental health care coordination are unlikely to be implemented in the U.S. Many vested interests would be affected by such changes across and within levels of government, and people with mental illness and their advocates lack the strength to compel broad change. Potent approaches to coordinating care (e.g. unifying funding – including control of hospital funds at the community level) have been implemented in a few states but not in most.

At the national level, the history of changes to facilitate coordinated mental health care is not encouraging. President Franklin Pierce vetoed legislation establishing a national construction program for state asylums in 1854, setting the tone for federal action on mental health services. The Community Mental Health Centers (CMHC) program originally proposed by President Kennedy sought to establish federal support for local community centers that would provide care and assure coordination. But the CMHC program was only partially and weakly implemented. Centers that received funding were given



seven year start-up grants rather than permanent funding, and by the time the program was converted to a block grant to the states in 1981, only a fraction of the needed centers had received funding.

President Carter secured passage of the Mental Health Systems Act in 1980, strengthening federal responsibility for mental health care. However, just a year later the Congress passed President Reagan's budget proposals that eliminated all major provisions of this legislation. Thus, the long history of U. S. federal action on mental health services reveals a consistent pattern of limited steps. Based on this history, federal reform to establish a strong framework for local coordination is extremely unlikely.

While calls for structural reform may continue, the analysis by Frank and Glied[8] makes a strong case that the well being of those with mental illness is more likely to be advanced by "mainstreaming": access to broad societal benefits (health insurance, housing, etc.) rather than by "exceptionalism." This trend is likely accelerated by the 2010 passage of comprehensive national health insurance reform. With the 2009 passage of health reform legislation requiring health insurance plans providing mental health benefits to provide them on an equitable basis relative to benefits for treatment of other illnesses, there will likely be an increased trend toward detecting and treating many mental health problems in the general health system. Indeed, in a recent article, I speculated that the long term future may result in a greatly reduced role for the specialty mental health system[16].

## State approaches to coordination

State governments in the U.S. accepted responsibility for mental health care in the 19th century with the construction of asylums. A century later, as the community mental health era emerged, many states enacted legislation to support the move to community care. New York State was the first, enacting legislation in 1954. Many states passed legislation in the 1960's, following the national lead of President Kennedy. Several characteristics of these laws would affect the movement to community care. First, the new state laws tended to encourage community care but did not encroach on the budgets or authorities of the state hospitals. In effect, states would have two systems of care – community services and state psychiatric hospitals. A second characteristic of state laws was to establish local responsibility for mental health care in a fashion consistent with that state's political tradition. In those states with a

tradition of strong county governments, mental health care was often made a county responsibility. In the New England states and others where counties were traditionally weak, the state's mental health agency would directly manage local services or designate a non-profit agency to manage the local system of care. Structures for leadership of mental health care and coordination varied from state to state, and generally the responsibility for administering specialty mental health services (clinics and other treatment programs, group homes, etc.) was lodged in a separate agency from those devoted to low-income housing, schools, rehabilitation, and overall health care.

The trend toward "mainstreaming" described by Frank and Glied[8] has further muddied the waters for coordination of care. A dominant force has been the trend toward use of Medicaid to fund mental health services. As the overall health care program for the poor and disabled, Medicaid's coverage of mental health treatment services has allowed expansion of community programs, facilitated the movement from hospital to community, and diluted the responsibility of state and local mental health agencies. This is in part because control of Medicaid rate-setting and benefit design lies with the designated state Medicaid agency – rather than the state mental health agency. And in part control has shifted because many states have turned to specialized "managed care" organizations to coordinate Medicaid mental health benefits, with an often diminished role for the state mental health agency.

While these trends are diverse and complex, two trends are evident. While a policy of "mainstreaming" tends to confer better access to benefits, it makes coordination once again more difficult. And it reduces even further the chances that structural solutions (such as a single local entity responsible for all services) can be employed to solve the problem of coordination. At the same time, these trends do not reduce the need for improving mental health care, and for better coordinated/integrated care. Indeed, they underline the challenge of improving coordination in communities where care is increasingly decentralized, with aspects provided by multiple agencies. What approaches can increase coordination in a system that is increasingly dispersed, complex and fragmented? And perhaps just as importantly, what emerging patterns of care can offer some hope or some practical strategies for improved coordination?



## Person-centered, recovery oriented care: A direction, and a solution?

In disability services internationally, a theme of empowering individuals through collaborative and "person centered" planning is emerging. Can a stronger commitment to person centered and recovery oriented care provide better ways to coordinate services and supports? As the trend is developing internationally, person centered approaches are better developed in the case of people with physical and intellectual disabilities. This may be partially because advocacy by and for these populations is more effective, and in part because many services to these individuals – as least in the U.S. – are funded as a "package" of care for the individual, creating a kind of personal budget that can be managed. Coordination via a personal services budget may be more unlikely in the case of individuals with serious mental illness, partly because these mechanisms are less available and partly because the experience and disability connected with mental illness often is quite variable for individuals over time.

However, in mental health, the emerging paradigm of "recovery" has the potential to change how services are delivered and to redefine the problem of services coordination. While the original connotation of recovery was relief from symptoms, Anthony's seminal article on recovery[17] borrowed heavily from the influence of consumer leaders, and defined recovery not as a clinical outcome, but as a personal process of adapting to illness/disability. A view of recovery as a process of adaptation rather than an outcome is beginning to become dominant. The President's New Freedom Commission on Mental Health[15] defined recovery as "the process by which people live, work, learn and participate fully in the community." The U.S. Substance Abuse and Mental Health Services Administration produced a National Consensus Statement on Mental Health Recovery[18] with the following definition: "Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential."

Mental health treatment and rehabilitation under this recovery framework assume the stance of assisting individuals with learning to live with an illness first, while treating the symptoms of the illness second. This change in emphasis is simple but profound. Traditional approaches to treatment and rehabilitation begin with assessment and diagnosis, valuing the individual's preferences but

keeping them essentially in "second position." The clinician or treatment team determines the goals of treatment; and the input of the patient/client affects how the goals will be met. Recovery oriented care is deeply person-centered. It borrows from the Individual Placement with Supports (PS) supported employment approach[19] which begins not with a rehabilitation skills assessment but with the person's choice of an employment goal, followed by a rapid job search followed by supports to keep the job. The emphasis is on assisting with developing and executing the individual's goals and plan, rather than following the treatment team's plan – modified perhaps based on the person's preferences.

While a recovery oriented and person centered approach to treatment and rehabilitation shifts the model of care toward a "clinical life coach" approach, it also affects how care is coordinated and integrated. The impetus for coordination shifts to the preferences of the individual, rather than the prescription of the treatment team. And the needs to be met shift significantly. The emphasis is less on simply coordinating modalities of treatment (e.g. medications, psychotherapy, vocational rehabilitation), and more on opportunities for participation in community life. This is illustrated by the dimensions of recovery cited in a consensus publication of the Ohio Department of Mental Health[20], listed in Table 2:

**Table 2:** Components of recovery (Ohio Departed of Mental Health 1999)

| Recovery Component: | Description of Component: |
|---|---|
| Clinical Care | Services that are provided by psychiatrists and other mental health professionals to promote and enhance the recovery process. |
| Family Support | Persons identified by the consumer as either family members or significant others who provide the necessary support for recovery. |
| Peer Support & Relationships | Friends, colleagues and other persons who provide the common understanding of issues and experiences impacting recovery. |
| Work/Meaningful Activity | Meaningful employment that provides both economic and psychological benefits, positively impacting the recovery process. |



| Recovery Component: | Description of Component: |
|---|---|
| Power and Control | Active engagement in care and personal decisions that promote recovery. |
| Stigma | Stereotypes associated with mental illness that hinder and/or negatively impact the recovery process. |
| Community Involvement | Activities and resources provided by the community to maintain consumers' social integration and affiliation with community. |
| Access to Resources | Ability to make contact with various people and places; use products, services and technologies that promote recovery. |
| Education | Both informal and formal methods of providing information that will result in behavioral changes. |

While clinical care was identified as a critical enabler of recovery in this publication, it was but one of nine components, with equal weight given to elements such as peer support, employment, and the ability to exercise power and control over one's life. From the recovery perspective, learning to live a good life despite an illness puts typical life challenges (relationships, work, living situation) in the foreground, while treatment issues – no less important in terms of symptom control – recede to the background.

On one hand, the challenges for service coordination and integration appear to become much more complex under a recovery perspective. If the challenge is not just to coordinate professional care, but also to address living circumstances and to facilitate rewarding personal relationships, the challenge seems impossible. But the other side of this approach is that the individual in recovery, with supports, becomes responsible for living their life and thus for navigating the community. Perspectives of consumer "recovery experts" show that this is the natural order of things. A study of consumer perspectives by consumer/researcher Jean Campbell and Ron Schraiber[21] revealed – in what should scarcely be a surprise – that consumers focus much more on the details and challenges of everyday life than on their "mental health life" of symptoms, visits and treatments.

A new research study just launched by the U.S. National Institute on Mental Health may illustrate how mental health practice may shift to blend treatment considerations with a recovery perspective, and to address coordination of care at the consumer level. The project, called Recovery After Initial Schizophrenia Episode is designed to refine, test and implement a recovery-oriented model for intervention during a first "psychotic break." The project builds on research into early and preventive interventions (e.g. McGorry and Jackson[22]), seeking to validate and produce a replicable model for early intervention.

Two research teams, headed by John Kane at Hillside Zucker Hospital, and Jeffrey Lieberman at New York State Psychiatric Institute/Columbia University (Lisa Dixon at the University of Maryland is co-Principal Investigator) are implementing and testing RAISE projects. While the models differ in some (mostly administrative) details, they share concepts that will shape future care for persons with serious mental illness. Obviously, a core component is to try and shift care toward immediate intervention. However, the core concept under RAISE is to combine and blend traditional treatments (e.g. an appropriate medication treatment) with a package of recovery oriented interventions. These are designed to meet two major goals, first to help the individual (and family) learn the adaptations needed to cope and live with the illness, and second to help them succeed with normative developmental and life challenges (e.g. gain and keep employment).

## Conclusion

Serious mental illness can result in significant disability and lead to the need for multiple supports and services – medical treatment, psychotherapy, rehabilitation, housing and income support for example. These services, housed under one roof during an era of institutional care, become much more difficult to coordinate in communities – especially in the U.S. where governments have divided powers. Coordination of care is often a problem, and "falling through the cracks" is criticized, but systematic solutions are difficult to achieve.

Coordination of care may involve a wide range of actions – legal, funding, organizational and clinical – that lead to integration, consistency and where possible convenience for the consumer/family. Because of the complexity of serious mental illness and the variability in how it is experienced, coordination of mental health care is very challenging. Limits on the role of government and on the ability to solve problems on behalf of a particular constituency mean that arrangements to provide coordination are likely to be incomplete.



A recovery paradigm for mental health makes coordination more complex, but also creates opportunities for improving the integration of care. Complexity is increased because the challenge in recovery is not just treatment, but helping people learn to live a decent life despite illness or disability. Dimensions such as friendships and careers become more important. More alternatives are in play, making the coordination task daunting. However, a recovery perspective recognizes that the person is at the center of their own experience. It empowers them to assert and take responsibility for their life rather than being dependent. A recovery perspective does not absolve mental health professionals or systems of their care or coordination responsibilities, but it expects they work in active partnership with empowered consumers and families in this challenge. Emerging models of person centered planning and care will assist on this journey.

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# Integrating Rehabilitation Services for Persons with Psychiatric Disabilities with the Mental Health, Health, and Welfare Systems: Lessons from the Experience in England*

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## Introduction

Mental health services are in a process of transformation in England at the start of the 21st century. The main aim of this paper is to highlight the development and content of current community care policies in English adult mental health. The chapter focuses on the building blocks of government policy and guidance for mental health services. I shall present a brief overview of the recent policy and legal changes that constitute key milestones in the development of community and hospital care policies (Table 1).

**Table 1:** Key Stages in the Development of Community Care Policy

| | |
|---|---|
| 1975 | Ministry of Health White Paper Better services for the Mentally Ill |
| 1983 | Mental Health Act |
| 1985 | House of Commons Social Services Select Committee Report on Community Care |
| 1986 | Audit Commission Report Making a Reality of Community Care |
| 1988 | Report by Sir Roy Griffiths. Community Care: Agenda for Action |
| 1990 | National Health Service and Community Care Act |
| 1990 | Department of Health Guidance 'Care Programme Approach' |
| 1992 | Department of Health 'Health of the Nation'. Mental Health a Key Area |
| 1994 | House of Commons Health Select Committee Report Better off in the community |
| 1994 | Introduction of Supervision Registers |
| 1996 | Mental Health (Patients in the Community) Act |
| 1999 | National Service Framework for Mental Health |
| 2000 | Policy Implementation Guidelines on new services published |
| 2011 | New mental health policy for England 'No health without mental health' |

* Presentation at the International Workshop, Rehabilitation and Community Integration of Persons with Psychiatric Disabilities: The Fitst Ten Years and Beyond, The Israel National Institute for Health Policy Research, October 13–14, 2010.

## The NHS and Community Care Act 1990

This 1990 Act was the culmination of a series of reports as mentioned in Table1. In 1985 the House of Commons Social Services Select Committee, under the chairmanship of Renee Short (hence called the 'Short Report') produced an authoritative review of community care provisions, and made 101 recommendations, concluding with the message that community care "cannot be and should not be done on cheap". The NHS and Community Care Act aimed to bring greater co-ordination to the provision of community care by the health and social services. The Act requires local social services and health authorities to jointly agree community care plans, which clearly indicate the local implementation of needs-based individual, care plans for long-term, severe and vulnerable psychiatric patients. The key objectives of the Community care act are listed in Table 2.

**Table 2:** Key Objectives of the NHS and Community Care Act, 1990

- To promote the development of domiciliary, day and respite services to enable people to live in their own homes wherever feasible and sensible
- To promote the development of a flourishing independent sector alongside good quality public services
- To co-ordinate of social care by the 'care manager'
- To make proper assessment of need
- To provide services on the basis of needs assessments to clarify the responsibilities of agencies and so make it easier to hold them to account for their performance
- To secure better value for taxpayers' money by introducing a new funding structure for social care.
- To ensure that service providers make practical support for carers a high priority

A key role that has been defined in the Act is that of the *care manager*. 'Care management' needs a special word of clarification. The term was introduced in 1991 as a variation of the term 'case manager' which had been used for the previous decade in the USA. Care manager describes the role of qualified social workers, who assess the needs of service users and who then purchase direct care services from other providers. It is different from the role of health service 'key workers' who assess needs and who then also provide direct care.



The Act makes the following statutory requirements of care managers:
'Where it appears to a local authority that any person for whom they may provide or arrange for the provision of community care services may be in need of any such services, the authority (a) shall carry out an assessment of his needs for those services and (b) having regard to the results of that assessment, shall then decide whether his needs call for the provision by them of any such services'.

This distinction is now less clear cut as many social workers are members of community mental health teams as 'care co-ordinators', the terms that was introduced in the 1999 revised of the Care Programme Approach, and this role effectively replaces the roles previously referred to a 'case manager' and 'key worker'.

## The Care Programme Approach

The Care Programme Approach (CPA) is guidance the government instructed mental health and social services to implement in 1991[1]. The CPA is still a central part of the government's mental health policy, and was brought in following concern that, after discharge, many service users did not have a named member of staff to contact, nor was there a defined care plan.

The CPA is the central process to be applied to adults in contact with specialist mental health and social care services, and the aim an integrated approach across health and social services. The key guiding principles in developing the CPA are the following: a service user focused approach, appropriate to the needs of the individual; to provide a framework to prevent service users falling through the net; to recognise the role of carers and the support they need; to facilitate movement of service users through the health care system according to need and service availability, to put into effect the full integration of health and social services; to copy to service users their care, and to include risk assessment and crisis contingencies in care planning.

In 2000 the three levels of the CPA were simplified in to two types of the CPA which are: Standard and Enhanced. The key features of the two current levels of the CPA are listed in Table 3[2].

**Table 3:** Care Programme Approach Levels

| | |
|---|---|
| Standard CPA | ♦ requires the support or intervention of one agency or discipline<br>♦ is more able to self-manage their mental health problems<br>♦ has an informal support network<br>♦ poses little danger to themselves or others<br>♦ is more likely to maintain contact with services<br>♦ no specific CPA paper-work required |
| Enhanced CPA | ♦ all service users who have been detained in hospital for over one month<br>♦ a requirement for multi-agency involvement & co-ordination<br>♦ individuals with a history of repeated relapse of their illness due to a breakdown in their medical and/or social care in the community<br>♦ individuals with severe social dysfunction, or major housing difficulties, as a consequence of their illness<br>♦ a history of serious suicidal risk, or self harm, severe self-neglect, violence, or dangerousness to others consequent on their illness<br>♦ patient will receive a written copy of their care plan<br>♦ have a care coordinator allocated with clear responsibilities and tasks agreed in the care programme<br>♦ have regular reviews for as long as this is deemed appropriate |

## Importance of the Care Programme Approach

The CPA represents a managed process of care, which remains as the cornerstone for all other aspects of policy for services for the adult severely mentally ill. The limitations of the CPA also need to be recognized, as it does not in itself contribute to the active therapeutic content of direct face-to-face treatment and support. There remain considerable local variations in how far the CPA has been implemented. The importance of the CPA is that it is designed to target resources to those who need them most, to ensure that vulnerable people do continue to receive the care they need, and to co-ordinate the delivery of such care[3].



## National Service Framework for Mental Health (1999)

A central element of current policy is the National Service Framework for Mental Health (NSFMH) and includes health promotion, primary care services, local mental health and social care services, those with mental health problems and substance misuse, and more specialized mental health services, including all forensic mental health services. This framework therefore encompasses a wide range of service activities including: those provided by local authorities and health authorities, and it draws upon a review of the vast array of relevant evidence, including related information from other countries[4].

The National Service Framework for Mental Health is a strategic blueprint for services for adults of working age. It is both mandatory, in being a clear statement of what services must seek to achieve in relation to the given standards and performance indicators, and permissive, in that it allows considerable local flexibility to customise the services which need to be provided to fit the framework[5] (Department of Health, 1999).

**The stated aims of the NSFMH are to:**

- help drive up quality
- remove the wide and unacceptable variations in provision.
- set national standards and defines service models for promoting mental health and treating mental illness
- put in place underpinning programmes to support local delivery
- establish milestones and a specific group of high-level performance indicators against which progress within agreed timescales will be measured.

**Core Values and Principles of the NSFMH**

A consensus on the fundamental values that should be used to guide practical service developments was developed, namely that services should:

- show openness and honesty
- demonstrate respect and offer courtesy
- be allocated fairly and provided equitably
- be proportional to their needs
- be open to learning and change

Upon this foundation services should also be guided by the following core fundamental principles, that users can expect services to:

- meaningfully involve users and their carers
- deliver high quality treatment and care which is effective and acceptable
- be non-discriminatory
- be accessible: help when and where it is needed
- promote user safety and that of their carers, staff and the wider public
- offer choices which promote independence
- be well coordinated between all staff and agencies
- empower and support their staff
- deliver continuity of care as long as needed
- be accountable to the public, users and carers

**National Standards**

In the NSFMH standards have been set in five areas:

- Standard 1 Mental health promotion
- Standards 2 & 3 Primary care and access to services
- Standards 4 & 5 Effective services for people with severe mental illness
- Standard 6 Caring about carers
- Standard 7 Preventing suicide

**Standard 1: Mental Health Promotion**

Health and social services should:

- promote mental health for all, working with individuals and communities
- combat discrimination against individuals and groups with mental health problems, and promote their social inclusion.

**Standard 2: Primary Care and Access to Services**

Any service user who contacts their primary health care team with a common mental health problem should:

- have their mental health needs identified and assessed
- be offered effective treatments, including referral to specialist services for further assessment, treatment and care if they require it.

**Standard 3: Primary Care and Access to Services**

Any individual with a common mental health problem should:

- be able to make contact round the clock with the local services necessary to meet their needs and receive adequate care
- be able to use NHS Direct, as it develops, for first-level advice and referral on to specialist help lines or to local services.



**Standard 4: Severe Mental Illness**

All mental health service users on CPA should:

- receive care which optimizes engagement, anticipates or prevents a crisis, and reduces risk
- have a copy of a written care plan which:
  - includes the action to be taken in a crisis by the service user, their carer, and their care coordinator
  - advises their GP how they should respond if the service user needs additional help
  - is regularly reviewed by their care co-ordinator
  - be able to access services 24 hours a day, 365 days a week.

**Standard 5: Severe Mental Illness**

Each service user who is assessed as requiring a period of care away from their home should have:

- timely access to an appropriate hospital bed or alternative bed or place, which is:
- in the least restrictive environment consistent with the need to protect them and the public
- as close to home as possible
- a copy of a written after care plan agreed on discharge, which sets out the care and rehabilitation to be provided, identifies the care co-ordinator, and specifies the action to be taken in a crisis.

**Standard 6: Caring about Carers**

All individuals who provide regular and substantial care for a person on CPA should:

- have an assessment of their caring, physical and mental health needs, repeated on at least an annual basis
- have their own written care plan that is given to them and implemented in discussion with them.

**Standard 7: Preventing Suicide**

Local health and social care communities should prevent suicides by:

- promoting mental health for all, working with individuals and communities (Standard 1)
- delivering high quality primary mental health care (Standard 2)
- ensuring that anyone with a mental health problem can contact local services via the primary care team, a help line or an A&E department (Standard 3)

- ensuring that individuals with severe and mental illness have a care plan which meets their specific needs, including access to services round the clock (Standard 4)
- providing safe hospital accommodation for individuals who need it (Standard 5)
- enabling individuals caring for someone with severe mental illness to receive the support which they need to continue to care (Standard 6).

## The NHS Plan

The creation of the NHS in 1948 was a seminal event. No longer would wealth determine access to healthcare need, irrespective of ability to pay, the NHS was an extraordinary act of emancipation. For that reason, the NHS retains, in its essential values, huge public support. But over twenty years, it had struggled. Its funding had not kept pace with the healthcare systems of comparable countries. Its systems of working are often little changed from the time it was founded, when in the meantime virtually every other service we can think of has changed fundamentally. So urgent was the need for extra money for the NHS that many of the failures of the system were masked or considered secondary. So the government decided to make an historic commitment to a sustained increase in NHS spending. Over five years it amounts to an increase of a third in real terms. Over time, the aim is to bring it up to the EU average. Money had to be accompanied by modernisation; investment, by reform. (Foreword by PM Tony Blair on NHS Plan, 2000)[6].

In relation to mental health, the NHS Plan adds more specific detail than the NSFMH in describing what services should be provided in each local area. It required the provision of:

- Early Intervention (EI) Teams
- Assertive Outreach (AO) Teams
- Crisis Resolution Teams[7,8].

## The balanced care model

The current concept of balanced care is now replacing approaches which previously relied on hospital-based care or community-based care alone[9]. Balanced care includes both modern community-based and modern hospital-based care. In balanced care the focus is upon services provided in normal community settings, as close to the population served as possible, and where



admissions to hospital can be arranged promptly, but only when necessary[10]. In periods of transition careful attention has to be paid the needs of staff for support and supervision[11]. Further, opposition is common to plans to develop community care, sometimes based upon a narrow and negative knowledge base available to members of the local community about mental health matters[12]. It is important to learn from previous experience worldwide when learning the lessons about how to develop a considered balance between hospital-based and community based care[13-15], and to base services as far as possible upon a firm evidence base[16].

## Appendix. Key recent mental health policy guidelines

**Mental health policy, implementation guidance and information**

***Acute inpatient care***

- Mental Health Policy Implementation Guide: Adult Acute Inpatient Care Provision
  http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4009156&chk=hdBfGn

- http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4010439&chk=XB8C8w

- Mental Health Policy Implementation Guide: Developing Positive Practice to Support the Safe and Therapeutic Management of Aggression and Violence in Mental Health In-patient settings

***Asylum-seekers***

- Caring for Dispersed Asylum-Seekers
- http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4010379&chk=fsxJo5

***Black and ethnic minority mental health***

- Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England
- http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/MentalHealth/MentalHealthArticle/fs/en?CONTENT_ID=4002020&chk=PFFceH
- Engaging and changing: developing effective policy for the care and treatment of black and minority ethnic detained patients
- Delivering Race Equality: A Framework for Action

***Carers***

- Developing services for carers and families of people with mental illness http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4009233&chk=qDc1ps

***Community Mental Health Teams***

- Mental Health Policy Implementation Guide: Community Mental Health Teams

***Dual Diagnosis and substance misuse***

- Mental Health Policy Implementation Guide Dual Diagnosis Good Practice Guide
  http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4009058&chk=sCQrQr
- Alcohol Harm Reduction Strategy for England

***Mental health promotion***

- 'Making it Happen'– a guide to mental health promotion
  http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4007907&chk=i2SwWZ

***Personality disorder***

- Personality Disorder: No longer a diagnosis of exclusion
- http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4009546&chk=BF%2B3ka



- Breaking the cycle of rejection: The Personality Disorder Capabilities Framework

***Social inclusion***

- Community Renewal and Mental Health Kings Fund and NIMHE
- Mental Health and Social Exclusion

***Support, Time and Recovery Workers***

- Mental Health Policy Implementation Guide: Support, Time and Recovery Workers
  http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4006254&chk=hSWweM

***Suicide prevention***

- National Suicide Prevention Strategy for England
- http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4009474&chk=sr1kpe

***Women's mental health***

- Mainstreaming Gender and Women's Mental Health: Implementation guidance
  http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4072067&chk=uuBKuS

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# Psychiatric Rehabilitation and Recovery*

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## Introduction

Psychiatric rehabilitation denotes a process for helping or enabling people who have substantial functional difficulties related to mental illness to improve their functioning through acquiring skills and supports. This review provides an update on five evidence-based psychiatric rehabilitation interventions, generalizes from them to current trends in the field, and links psychiatric rehabilitation to the recovery movement. Details regarding the studies and interventions as well as various aspects of recovery in relation to psychiatric rehabilitation are provided in our textbook (Corrigan, Mueser, Bond, Drake, & Solomon, 2008).

Definitions of recovery are legion. The central features of these definitions include pursuing personal life goals such as independence, meaningful activities, and relationships as well as avoiding the state of being overwhelmed or defeated by mental illness. Literally thousands of personal testimonies emphasize these themes. One central question is, does psychiatric rehabilitation promote these outcomes?

Psychiatric rehabilitation began as peer support for recovery when long-term patients discharged from state hospitals in New York met on the steps of the public library for mutual support. As professionals became involved, services continued to emphasize respect for the individual, peer support, personal preferences, human rights, and social justice. People were helped to achieve their highly individualized functional goals by increasing their skills and supports. Early rehabilitation models were not tested empirically by standard scientific methods, but research has steadily increased over the past 20 years as part of the evidence-based practices movement.

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Evidence-based practices are interventions that are defined carefully, usually by manuals and rating scales, and tested by more than one research group in randomized controlled trials. In addition, evidence-based practices in psychiatric rehabilitation are client-centered, focusing on individualized goals identified by people with mental illnesses themselves, and using informed choice or shared decision-making.

The field of psychiatric rehabilitation has developed numerous evidence-based practices. The National Evidence-based Practices Project in the U.S. studied five practices: assertive community treatment, supported employment, integrated dual disorders treatment, illness management and recovery, and family psychoeducation. The following discussion describes each of these interventions, summarizes the research, and overviews current issues.

## Assertive Community Treatment

Assertive community treatment, the prototypical community mental health intervention, was developed in the 1970s. It is a community-based program in which a multi-disciplinary team of clinicians helps a discrete group of clients to live independently in the community and stay out of the hospital by providing 24-hour services and supports seven-days a week. Individualized interventions help people to learn skills and acquire supports to maintain community residences and avoid institutionalization or homelessness. For example, workers may help clients learn to maintain an apartment, wash clothes, shop for groceries, use medications effectively, and take public transportation. Importantly, these services are provided in the community rather than in mental health clinics or hospitals.

Assertive community treatment was the most widely studied psychosocial intervention for people with serious mental disorders during the 1980s and 1990s. Consistent effectiveness findings have included decreased hospitalization, enhanced community tenure, and high satisfaction with services, but not functional outcomes such as work and social relationships. The assertive community treatment model has been flexible enough to incorporate family psychoeducation, supported employment, substance abuse treatment, and other new interventions over time.

Despite its preeminence, assertive community treatment has been severely challenged by changes in the community mental health system in the U.S. and elsewhere. First, in many areas the mental health system has reduced lengths



of hospitalization to a few days for all but a residual group of patients with forensic issues. Thus, the basic argument for cost-effectiveness of assertive community treatment – that it is less costly than long-term hospitalization – has been undercut. Second, the reduction over many years of funding for psychosocial services in the U.S. due to the enormous costs of new medications, attempts to slow the growth of Medicaid, and state revenue shortfalls have stopped the expansion of assertive community treatment. Third, many primary components of assertive community treatment have been broadly adopted by other case management teams with the net result that the interventions can appear similar except for intensity. Fourth, assertive community treatment teams have not developed clear guidelines for transitioning clients in order to create capacity to help new clients. Many teams are filled with relatively stable clients but are unwilling to take on new ones. Fifth, the traditional target population of assertive community treatment – people with severe and persistent mental illness – has expanded in many areas to include forensic clients, sex offenders, people with severe personality disorders, and other populations. These new populations offer substantially different clinical challenges and often confuse and frustrate clinicians. Sixth, some recovery-oriented aspects of the model have yet to be clarified, for example, the use or avoidance of coercive interventions. For all of these reasons, the future of assertive community treatment is unclear.

## Supported Employment

Supported employment is a team-based approach that integrates vocational and mental health services in order to help clients find and succeed in competitive employment. The approach steadfastly adheres to client preferences regarding timing of searching for a job, type of job, hours of work, amount of disclosure, job supports, and so forth. Supported employment specialists work with clients out in the community to develop jobs, to secure employment, and to provide whatever supports and training the client needs to succeed on the job.

The research on evidence-based supported employment – called Individual Placement and Support (IPS) – is extensive and consistent. Across more than a dozen randomized controlled trials in several countries, about two-thirds of people with serious mental illnesses who receive IPS supported employment achieve competitive employment, a rate that is two to three times higher than that achieved in alternative vocational programs. IPS participants also work more hours, earn more wages, and report other benefits such as increased self-

esteem and quality of life. Long-term follow-ups show that people continue to work as much or more over several years and that steady workers dramatically reduce their use of mental health services.

Current research on IPS supported employment is extensive. Early intervention teams are attempting to combine supported employment and supported education to people early in the course of illness, for example, those who are experiencing a first episode of schizophrenia or other psychotic illnesses, to prevent disability. Policy makers in the U.S. are trying to reform insurance and disability regulations so that they align with supported employment goals. Researchers are also trying to improve IPS supported employment outcomes for the one-third of clients who currently do not benefit. Much of this research focuses on cognitive deficits, which are considered a key barrier to employment. Added interventions typically combine compensatory and/or skill-building (remediation) components. Others are attempting to fit IPS supported employment into new settings, such as peer-support programs or clubhouses.

## Integrated Dual Disorders Treatment

Integrated dual disorders treatment targets the problem of co-occurring substance use disorders by combining mental health and substance abuse treatments within multi-disciplinary teams. The teams typically outreach to clients in their community living settings, homeless shelters, jails/prisons, or wherever they are. The interventions are motivational, aiming toward harm reduction and dual recovery.

Although there is little consistency across these interventions, research on integrated dual disorders treatment shows that substance use disorder outcomes can be enhanced, especially through group and residential interventions. Research also shows that other evidence-based practices are effective on other areas of adjustment. For example, supported housing helps people with dual disorders to maintain housing, and IPS supported employment helps them to gain jobs. Many widely used interventions, such as day programs, family interventions, 12-step programs, and legal monitoring, have received little research attention.

One goal of current research is to refine and standardize critical interventions, for example, specific approaches to individual counseling, family interventions, and intensive outpatient programs. These questions need to be answered



before widespread dissemination and training are possible. Second, assessment issues remain to be resolved. Measuring effectiveness by self-report alone is complicated by legal and other contingencies. Few mental health agencies have the capacity for laboratory monitoring, hair analysis, and collateral interviews. Third, heterogeneity profoundly affects participation and outcomes, but has not been controlled for in most studies. For example, some clients are actively pursuing abstinence when they enter treatment, while others are denying that their substance use is problematic. Current studies emphasize stages of recovery and sometimes provide staged treatments. A fourth issue involves the cultural evolution of drug use patterns. For most of the past 20 years, alcohol and cannabis have been the predominant drugs of abuse in the U.S., but today methamphetamine and prescription opiates are becoming more prominent.

## Illness Management and Recovery

The illness management and recovery intervention combines several evidence-based strategies for self-management of serious mental illnesses. Educational, motivational, behavioral, and cognitive-behavioral strategies are taught in a series of modules that cover topics such as reducing stress, recognizing early warning signs and avoiding relapses, and coping with residual symptoms. Based on a structured curriculum and a general skills training approach, the intervention helps people to break their goals down into small manageable units, to take steps toward achieving the goals, and to learn to manage their illnesses in the process of working on personal goals.

Illness management and recovery as a complete package is a new synthesis of effective intervention. Most of the components, e.g., relapse prevention, have been previously validated. The initial research, including a randomized controlled trial in Israel, has demonstrated positive effects on illness management outcomes such as using positive coping strategies.

Illness management and recovery, as a new intervention, needs considerable research. One line of current research involves feasibility. For example, can and should this intervention be delivered by assertive community treatment teams and within peer support centers? A second area of investigation involves the boundaries of illness management and recovery. Should the intervention include management of substance use disorders, physical health problems, and other problems? If so, how should the intervention be integrated with other efforts in these areas?

## Family Psychoeducation

Most people living in the community with serious mental illnesses have extensive contacts with family members or intimate partners. Family psychoeducation is a highly structured approach that helps family members to understand mental illness and its treatments, to learn skills for helping their relatives to manage illnesses, and to develop supports for themselves in the community. The intervention was originally used to engage families during their relatives' inpatient hospitalizations with sessions over several months extending into the outpatient setting. Several permutations of family psychoeducation have been developed, for example, approaches with single families, with multiple families, with or without the identified client present, and with or without teaching specific behavioral problem-solving strategies.

Research on family psychoeducation has consistently shown positive results. The intervention helps families to understand mental illness, to be more effective in handling daily issues as well as crises, and to feel less stress. In addition, the clients themselves appear to benefit, at least in terms of avoiding relapses and hospitalizations.

The major research issue regarding family psychoeducation is usability. Although many insurance systems will pay for family sessions, clinicians have been reluctant to adopt the family psychoeducation model and most clients and families have been unwilling to commit to a lengthy and structured process. As a result, the intervention has not been widely disseminated and has been discontinued in many places where it has been implemented. At the same time, families, policy makers, and researchers have been actively searching for simpler, more practical, more appealing methods of helping families. One such approach, the family-to-family model, is delivered by families to other families, and appears to be more acceptable to a large number of families. Other models of family intervention are also being developed and studied, but research on the traditional, highly structured family psychoeducation model has largely died out.

## General Themes

Several themes should be clear in this brief overview. Evidence-based psychiatric rehabilitation practices embody several common features. They are client-centered, paying close attention to the client's goals and preferences. They use multi-disciplinary teams, thereby coordinating and integrating care for people who often have multiple intertwined needs. They are highly individualized, combining and tailoring interventions that are relevant for an individual. And they are delivered in the community, rather than in clinics, enabling people to acquire skills and supports in their natural living environments, directly promoting social inclusion. These features suggest that practices become evidence-based and durable because they are recovery-oriented, that is, because they enhance each individual's personal journey toward meaningful functional goals.



Effective interventions are simple, straightforward, usable, and attractive to clients and clinicians. Practices that are complicated, cumbersome, or indirect (e.g., expecting insight to result in behavioral change) are unlikely to become evidence-based practices and unlikely to be adopted in real-world settings. Like family psychoeducation, many practices that are studied in university settings (efficacy) are never adopted in real routine treatment settings (effectiveness).

## Conclusions

Psychiatric rehabilitation has evolved rapidly over the past 20 years, as effectiveness research has been used to define evidence-based practices. Effective rehabilitation practices are client-centered, provided by multi-disciplinary teams, highly individualized, and delivered in natural community settings.

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Corrigan, P.W., Mueser, K.T., Bond, G.R., Drake, R.E., Solomon, P. *The Principles and Practice of Psychiatric Rehabilitation*. New York: Guilford Press, 2008.

# Understanding and Supporting Personal Recovery*

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The focus of the mental health system in the 1800s was on exclusion, and in the 1900s was on treatment. The emerging focus of international mental health systems for this century is on recovery. The consumer-developed idea of recovery now underpins mental health policy in many countries. Yet turning this recovery rhetoric into reality is a challenge. Personal recovery is different from clinical recovery. Supporting personal recovery is a mental health policy goal in many countries[1-5]. This policy is driven by an ideological orientation towards citizenship and social inclusion for people experiencing mental ill-health, and is in advance of the scientific evidence[6, 7].

## What is recovery?

The term 'recovery' is at the heart of a debate about the core purpose of mental health services. It is a contested term, with at least two meanings. We call these two meanings recovery from mental illness, or 'clinical recovery', on the one hand, and being in recovery with a mental illness, or 'personal recovery', on the other8. Each meaning is underpinned by a set of values, and creates role expectations for mental health professionals. We begin by differentiating these two meanings.

**Meaning 1: Clinical recovery or recovery "from" mental illness**
The first meaning of recovery has emerged from professional-led research and practice. Clinical recovery has four key features:

1. It is an outcome or a state, generally dichotomous
2. It is observable – in clinical parlance, it is objective, not subjective
3. It is rated by the expert clinician, not the patient
4. The definition of recovery is invariant across individuals

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Various definitions of recovery have been proposed by mental health professionals. A widely-used definition is that recovery comprises full symptom remission, full or part-time work or education, independent living without supervision by informal carers, and having friends with whom activities can be shared, all sustained for a period of two years9. Defining recovery has allowed epidemiological research to establish recovery rates. In Table 1 we show all 20-year or longer follow-up studies published until 2008.

**Table 1:** Recovery rates in long-term follow-up studies of psychosis

| Lead | n | Follow-up (years) | % Recovered or significantly improved |
|---|---|---|---|
| Huber[10] | 502 | 22 | 57 |
| Ciompi[11] | 289 | 37 | 53 |
| Bleuler[12] | 208 | 23 | 53-68 |
| Tsuang[13] | 186 | 35 | 46 |
| Harding[14] | 269 | 32 | 62-68 |
| Ogawa[15] | 140 | 23 | 57 |
| Marneros[16] | 249 | 25 | 58 |
| DeSisto[17] | 269 | 35 | 49 |
| Harrison[18] | 776 | 25 | 56 |

These empirical data challenge the applicability of a chronic disease model to mental illness, with its embedded assumption that conditions like schizophrenia are necessarily life-long and have a deteriorating course.

However, deep assumptions about normality are embedded in clinical recovery. As Ruth Ralph and Patrick Corrigan comment in relation to clinical recovery[19]:

*This kind of definition begs several questions that need to be addressed to come up with an understanding of recovery as outcome: How many goals must be achieved to be considered recovered? For that matter, how much life success is considered "normal"? (p. 5)*

As a result, and as a product of the user/survivor movement spanning the last forty years, people who use mental health services have called for a new approach. As Ridgway argues[20]:

*The field of psychiatric disabilities requires an enriched knowledge base and literature to guide innovation in policy and practice under a recovery paradigm. We must reach beyond our storehouse of writings that describe psychiatric disorder as a catastrophic life event.*

The second meaning of 'recovery' provides the rubric under which such an enriched knowledge base has been accruing.

**Meaning 2: Personal recovery or being "in" recovery**

People personally affected by mental illness have become increasingly vocal in communicating both what their life is like with the mental illness and what helps in moving beyond the role of a patient with mental illness. Early accounts were written by individual pioneers[21-23]. These brave, and sometimes oppositional and challenging, voices provide ecologically valid pointers to what recovery looks and feels like from the inside.

Once individual stories were more visible, compilations and syntheses of these accounts began to emerge from around the (especially Anglophone) world, e.g. from Australia[24], New Zealand[25], Scotland[26], the USA[27] and England[28]. The understanding of recovery which has emerged from these accounts has a different focus from clinical recovery, for example in emphasising the centrality of hope, identity, meaning, and personal responsibility[24].

We will refer to this consumer-based understanding of recovery as **personal recovery**, to reflect its individually defined and experienced nature. To note, other distinguishing terms have also been used, including clinical recovery versus social recovery[29], scientific versus consumer models of recovery[30], and service-based recovery versus user-based recovery[31].

The most widely-cited definition, which underpins most recovery policy internationally, is by Bill Anthony[32]:

*Recovery is a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness.*



It is consistent with the less widely-cited but more succinct definition proposed by Retta Andresen and colleagues, that recovery involves[24]:

*The establishment of a fulfilling, meaningful life and a positive sense of identity founded on hopefulness and self determination.*

For those who value succinctness, the definition used in our local mental health service in South London is[33]:

Recovery involves living as well as possible.

## Recovery research

Our research has focused on developing an empirical evidence base relating to personal recovery. We briefly describe two products from this work.

First, the **Personal Recovery Framework** provides an evidence-based framework for mental health professionals to understand the processes involved in personal recovery[34]. The Personal Recovery Framework gives primacy to personhood over illness, and identifies four ways in which services can support personal recovery: Fostering relationships, Promoting well-being, Offering treatments and improving social inclusion. Mental health workers support recovery using many existing skills, and will also need to develop new skills. Supporting recovery has implications for relationships[35], incorporation of well-being and positive psychology research into routine practice[36], assessment processes[37], service evaluation[38], support when in crisis[39], and anti-stigma initiatives[40]. This framework has been published in an accessible free-to-download version[41], downloadable from rethink.org/100ways.

Second, we have just completed the first **systematic review** of personal recovery[42]. In this study, 97 papers were included from 5,208 papers identified and 366 reviewed. The emergent conceptual framework consists of: i) thirteen Characteristics of the Recovery Journey; ii) five Recovery Processes comprising Connectedness, Hope and optimism about the future, Identity, Meaning in life and Empowerment (giving the acronym CHIME); and iii) Recovery Stage descriptions which mapped onto the Transtheoretical Model of Change[43]. Studies focused on recovery for Black and Minority Ethnic (BME) individuals showed a greater emphasis on Spirituality and Stigma and also identified two additional themes: Culturally specific facilitating factors and Collectivist notions of recovery.

The Personal Recovery Framework and the systematic review have underpinned a programme of work involving the development of a new measure of recovery orientation called INSPIRE (researchintorecovery.com/inspire), a national survey of the perspectives of mental health service users, workers and team leaders on recovery, and a multi-site cluster randomised controlled trial (ISRCTN02507940) currently underway in South London and Gloucestershire in England, evaluating the impact of implementing a pro-recovery team intervention in 30 adult mental health teams. The intervention manual is free to download at researchintorecovery.com/refocus, and further information about this programme of work can be found at researchintorecovery.com.



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# Appendices

# Workshop Program
# Rehabilitation and Community Integration of Persons with Psychiatric Disabilities: The First Ten Years and Beyond

October 13-14, 2010
Hotel Dan Caesarea, Israel

**Wednesday, October 13, 2010**

| | |
|---|---|
| 09:00 – 10:00 | **Gathering & Morning Coffee** |
| 10:00 – 10:30 | Opening Session: Chairperson – Uri Aviram |
| Greetings: | **Gadi Lubin**, Head, Israel Mental Health Services, Ministry of Health<br>**Tamar Goz'ansky**, Former Member of the Knesset |
| 10:30 – 12:30 | **First Session:** Psychiatric Rehabilitation in Israel: The Law and Its Implementation |
| Chairperson: | **Eli Shamir**<br>**Uri Aviram:** Principles and Issues<br>**Yechiel Shereshevsky:** The First Decade – Assessment and Dilemmas<br>**Discussion** |
| 12:30 – 13:30 | Lunch |
| 13:30 – 15:30 | **Second Session:** Integrating Rehabilitation Services for Persons with Psychiatric Disabilities with the Mental Health, Health, and Welfare Systems: Lessons from the American and the British Experience |
| Chairperson: | **Shlomo Kravetz**<br>**Michael Hogan:** Lessons from the American Experience<br>**Graham Thornicroft:** Lessons from the British Experience<br>**Questions & Answers** |
| 15:40 – 16:00 | Coffee Break |
| 16:00 – 18:00 | **Third Session:** What Can Israel Learn from the American and the British Experience? |
| Chairperson: | **Yigal Ginath:** Comments on Trends and Issues of Systems Integration in the U.S. and the U.K: Israeli Perspectives |
| Panel: | **Michael Hogan, Graham Thornicroft, Robert Drake, Mike Slade**<br>**Discussion** |
| 20:00 – 22:30 | Dinner & Social Program: The Knafayim (Wings) Group |

**Thursday, October 14, 2010**

09:00 – 11:00 **Fourth Session:** Rehabilitation, Recovery, and Integration in the Community of Persons with Psychiatric Disabilities: An International Perspective

Chairperson: **Moshe Kotler**

**Robert Drake:** Rehabilitation and Recovery: Evidence–Based Practice

**Mike Slade:** Recovery of Persons with Psychiatric Disabilities: Conceptualization and Implementation

**Questions & Answers**

11:00 – 11:30 Coffee Break

11:30 – 13:00 **Fifth Session:** Rehabilitation, Recovery, and Integration in the Community of Persons with Psychiatric Disabilities: An Israeli Perspective

Chairperson: **David Roe:** Comments on the Rehabilitation, Recovery, and Integration in the Community in the U.S. and the U.K: An Israeli Perspective

Panel: **Robert Drake, Mike Slade, Michael Hogan, Graham Thornicroft**

**Discussion**

13:00 – 14:00 Lunch

14:00 – 16:30 **Sixth Session:** Toward the Second Decade

Chairperson: **Alik Aviram**

**Yigal Ginath:** Comments on the Lectures and Discussions on Integrating Rehabilitation Services for Persons with Psychiatric Disabilities with the Mental Health, Health, and Welfare Systems

**David Roe:** Comments on the Lectures and Discussions on Rehabilitation, Recovery, and Integration in the Community of Persons with Psychiatric Disabilities

**Discussion:** Questions and comments from audience
Response and Comments by International Panelists

**Concluding Remarks: Uri Aviram**

Coffee to Go



# Rehabilitation of the Mentally Disabled in the Community Law, (2000***)

**1. Purpose**

The purpose of this Law is to strive for and advance the rehabilitation and integration of the mentally disabled in the community in order to allow them to achieve the maximum degree of functional independence and the highest possible quality of life, while preserving their dignity in the spirit of the Basic Law: Human Dignity and Liberty[1].

**2. Definitions**

In this Law, the following definitions will apply -

"Regional Rehabilitation Committee"- a Regional Rehabilitation Committee established pursuant to Section 13;

"Occupational Therapist" – a person recognized by the Director-General of the Ministry of Health, in writing, as being an occupational therapist for the purpose of this Law;

"Mentally Disabled Person" – a resident of Israel who suffers from a mental disorder;

"Rehabilitation Basket" – the basket of Rehabilitation Services provided in the areas listed in the Supplement to this Law;

"Professional Worker" – any of the following: a Psychiatrist, Psychologist, Social Worker, Occupational Therapist, Nursing Care Provider, and any other professional recognized by the Director-General of the Ministry of Health, in the official gazette, as being a professional worker for the purpose of this Law;

"Nursing Care Provider" – a person listed in the Register of Nursing Care Providers, pursuant to the Public Health Ordinance, 1940[2];

"Psychologist" – a person listed in the Register of Psychologists pursuant to the Psychologists Law, 1977[3];

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* The English translation has attempted to preserve the original version of the law, though some of the language may not be suitable for the language used today.

** Accepted at the Knesset July 11, 2000, the law proposal and explanations were published in HH (Hatzaot Khok) 2782 (Law Proposals-2782), December 28, 1998, p. 222. Published SH (Sefer Hakhukim), 2000 (Book of Laws-2000), No. 1746, July 21, 2000, p. 231. (HH 2000 No. 2782, p. 222.) Entered into force six months after publication

[1] SH, 1992, p. 150.

[2] Ikon Rishmi, 1940 (The Official Gazette-1940), supplement 1, p. 191.

[3] SH, 1977, p. 158

Psychiatrist" – a physician with a specialist's degree in psychiatry or in child and adolescent psychiatry pursuant to the Physicians Law [New Version], 1976[4];

"Rehabilitation" – a process within the framework of the community, directed at the development of the abilities and skills of the Mentally Disabled Person, so as to ensure for him or her the maximum possible level of functional independence and quality of life – a process accompanied by medical supervision, including each of the following:

(1) The realization of the rights of the Mentally Disabled Person in the areas of housing, employment, education and professional training;

(2) Training of a Mentally Disabled Person with regard to his or her social skills and utilization of his or her leisure time;

"Rehabilitation Service"- a service, the purpose of which is to promote the rehabilitation of a Mentally Disabled Person;

"Rehabilitation Program" – a program for the rehabilitation of a particular Mentally Disabled Person, established for such person by the Regional Rehabilitation Committee in accordance with the Rehabilitation Basket;

"Regulations for Determination of Percentage of Disability" – the National Insurance Regulations (Determination of Degree of Disability for Victims of Work Related Accidents), 1956[5];

"The Minister" – The Minister of Health.

**3. Eligibility for Rehabilitation**

(a) A Mentally Disabled Person aged 18 years or older, and who suffers from a medical disability due to a mental disorder, or a person acting on his or her behalf, may apply to the Regional Rehabilitation Committee in order to determine his or her eligibility for a Rehabilitation Program pursuant to this Law; the application must be accompanied by a professional opinion from a psychiatrist establishing that the applicant for the rehabilitation requires Rehabilitation Services due to his or her disability.

(b) For the purpose of sub-section (a), a medical disability due to a mental disorder will mean a disability of at least 40%, determined according to articles 33 or 34 of the Supplement to the Regulations for Determination of Percentage of Disability, by one of the following:

(1) a psychiatrist, authorized by the Minister, according to the rules, tests and criteria established in the Regulations for Determination of a Disability Percentage;

[4] Laws of the State of Israel, new version 30, p. 594.

[5] Regulation files, 1956, p. 864.



(2) a party authorized to determine a disability percentage for the purpose of payment of a pension pursuant to the provisions of Chapters E or I of the National Insurance Law [Integrated Version] -1995[6].

**4. The National Rehabilitation Council**

The Minister will appoint a National Council for rehabilitation of mentally disabled in the community, (hereinafter "the Council"), to be composed of 23 members who shall be: -

(1) The Minister's representative, who shall be an employee of the Ministry of Health, and who will chair the Council;

(2) A Psychiatrist who is a representative of the organization which, in the Minister's opinion, represents the largest number of psychiatrists;

(3) A Psychologist who is a representative of the organization which, in the Minister's opinion, represents the largest number of psychologists;

(4) A Social Worker who is a representative of the organization which, according to the Minister, represents the largest number of social workers;

(5) An Occupational Therapist who is a representative of the organization which, in the Minister's opinion, represents the largest number of occupational therapists;

(6) A Nursing Care Provider who is the representative of the organization which, in the Minister's opinion, represents the largest number of nursing care providers;

(7) Two representatives of organizations which, in the Minister's opinion, represent the mentally disabled

(8) Two representatives of organizations which, in the Minister's opinion, represent the families of the mentally disabled

(9) Eight representatives of the Government, appointed at the recommendation of each of the following ministers, from among the employees of their respective ministries:

a. The Minister of Construction and Housing;

b. The Minister of Labor, Welfare, and Health;

c. The Minister of Finance;

d. The Minister of Education;

[6] SH, 1995, p. 210.

e. The Minister of Justice;

f. The Minister of Defense;

g. The Minister of Immigrant Absorption;

h. The Minister of Industry and Trade;

(10) A representative of the Center for Local Government;

(11) A representative who is an employee of the National Insurance Institute, at the recommendation of the Director-General of the National Insurance Institute;

(12) Three representatives of the recognized institutions for higher education, as defined in the Higher Education Council Law, 1958[7] (hereinafter: "Recognized Institutions for Higher Education"), who have specialized in fields relating to the rehabilitation of the mentally disabled in the community; the representatives appointed pursuant to this paragraph will be chosen at the recommendation of the existing institutions, and in the absence of such a recommendation, will be chosen as recommended by the Minister;

**5. The Council's Functions**

The following shall be the Council's functions:-

(1) To advise the Minister regarding the rehabilitation of the mentally disabled, including, *inter alia*, with regard to the following matters;

(a) Outlining a multi-year national rehabilitation policy;

(b) Planning of Rehabilitation Services in the community and of the improvement of the quality, availability and accessibility thereof, and of methods for promoting equality with regard to all of these;

(c) The development of community-based educational and public relations programs, regarding all topics related to the mentally disabled;

(d) Modifications of the list of services included in the Rehabilitation Services Basket;

(e) Establishment of standards to be used in assessing Rehabilitation Service providers;

7 SH, 1958, p. 191.



(2) To receive reports and data regarding the implementation of the Law;

(3) To initiate research projects regarding rehabilitation topics.

**6. Duration of terms of office**

The members of the Council will be appointed for four years and can then be appointed for an additional continuous term, provided that no Council member who has served two continuous terms may be appointed for an additional term during the four years following the end of his or her second consecutive term.

**7. Qualification regarding the appointment**

A person may not be appointed to serve as a member of the Council if he or she has been convicted of a crime which, by its nature, severity or the circumstances thereof, such person's service as a member of the Council is inappropriate.

**8. Expiration of term of office**

A Council member will cease to serve on the Council before the end of his or her term in any of the following circumstances:

(1) The member has resigned by delivering a letter of resignation to the Minister;

(2) The member has been convicted of a crime, and because of the crime's nature, severity or circumstances, continued membership in the Council is inappropriate;

(3) The member is no longer an employee of the government ministry or of the entity which he or she represents in the Council.

**9. Removal from office**

The Minister may remove a Council member from the Council, prior to the end of his or her term, if the member has become permanently unable to carry out his or her duties as a member of the council.

**10. Legal force of actions**

The existence of the Council, its powers, and the validity of its resolutions will not be affected by the fact that one of the positions on the Council has been vacated or because of a defect in the appointment of a member or in a member's continuation in office.

**11. Meetings**

(a) The Council will meet at least four times each year; the Council's chair or a third of its members may convene an additional Council meeting.

(b) The Council's chair will convene the meetings and determine their dates, locations and agendas, provided that the chair must convene a meeting at the request of Council members as stated in sub-section (a), within 21 days after the date of the request.

**12. Procedures at meetings**

(a)

(1) The legal quorum for Council meetings shall be ten members, including the Council chair;

(2) Once a meeting has begun with a legal quorum present, the continuation of the meeting shall be valid, regardless of the number of those present, provided that at the time that resolutions are adopted, there are at least three members present, including the chair.

(b) Council resolutions shall be adopted on the basis of a majority vote of the members participating in the vote; if there is a tie vote, the chair's vote will be determinative.

(c) The Council will establish its own work procedures to the extent that such are not established in this Law.

**13. Regional Rehabilitation Committees**

(a) The Minister will establish Regional Rehabilitation Committees, and will determine the area of each committee's geographic responsibility.

(b) A Regional Rehabilitation Committee will have three members, who shall all be Professional Workers, and at least two of whom shall have different areas of expertise; one member will be a State employee, who will chair the committee.

**14. Functions of a Regional Rehabilitation Committee**

(a) A Regional Rehabilitation Committee will examine the eligibility for a Rehabilitation Program of a Mentally Disabled Person who has applied to the Committee, or whose case has been brought before the Committee pursuant to the provisions of Section 3.

(b) Should a Regional Rehabilitation Committee find that a Mentally Disabled Person is eligible for a Rehabilitation Program, it will establish a Rehabilitation Program for him or her, which will be comprised of services included in the Rehabilitation Basket and will be of the scope that the Committee has established, subject to the scope of services



established pursuant to Section 25.

(c) A Regional Rehabilitation Committee may approve the reimbursement of expenses incurred by a Mentally Disabled Person traveling by public transportation in connection with the implementation of a Rehabilitation Program.

(d) A Regional Rehabilitation Committee will, at six month intervals, review the Rehabilitation Program that was established for the Mentally Disabled Person in order to evaluate its suitability.

(e) A Regional Rehabilitation Committee may, at any time, either at the request of the Mentally Disabled Person or of someone acting on such a person's behalf, or at the recommendation of a Professional Worker, alter the Rehabilitation Program that was established for the Mentally Disabled Person.

(f) The resolutions of a Regional Rehabilitation Committee will be adopted on the basis of a majority vote of its members. Should the votes be tied, the chair's vote will be determinative.

(g) A Regional Rehabilitation Committee will establish its own work procedures to the extent that they have not been established pursuant to this Law.

**15. Powers of a Regional Rehabilitation Committee**

(a) For the purpose of carrying out its functions, the Regional Rehabilitation Committee may, subject to any relevant legal provisions - including the provisions relating to medical confidentiality: refer a Mentally Disabled Person for a functional psychiatric evaluation; review his or her medical file; hear and obtain the professional opinion of experts in various fields; hear the Mentally Disabled Person or his or her family members or other interested parties; and may request, from the Mentally Disabled Person or from his or her representative, any information that it requires, all as the Committee may determine.

(b) The Regional Rehabilitation Committee may, at any time and subject to any relevant law, request information from any person connected to the case regarding the integration of the Mentally Disabled Person into the Rehabilitation Program.

(c) If a person is asked to provide information as stated, such a person shall comply no later than fourteen days from the date on which the request is received, notwithstanding any provision in any relevant law prohibiting the transfer of information.

**16. District Appeals Committees**

(a) The Minister will establish District Appeals Committees and will determine the area of each committee's geographic responsibility.

(b) Each District Appeals Committee will be comprised of five members. Its composition will be the following:

(1) A person qualified to be appointed as a Magistrate's Court judge, from a list prepared by the Minister of Justice, and such person will serve as chair of the Committee;

(2) Three Professional Workers, each having a different field of expertise;

(3) A representative of the public.

(c) The Minister may establish rules regarding the qualifications required for a member of the District Appeals Committee, a member's term of office, and the rules for removal of a member of the Appeals Committee from his or her position on the Committee.

**17. Submission of an Appeal**

(a) A Regional Rehabilitation Committee decision made pursuant to section 14 may be appealed by any person connected to the matter, or by the Minister or by any person acting on the Minister's behalf; the appeal may be submitted within forty-five days from the date on which a notice regarding the decision of the Regional Rehabilitation Committee was delivered to the Mentally Disabled Person or to a person acting on his or her behalf.

(b) The District Appeals Committee will decide the appeal no later than sixty days after its submission.

(c) The District Appeals Committee may approve, cancel or modify the decision which is the subject of the appeal.

(d) The decisions of the District Appeals Committee will be adopted through a majority vote of its members.

(e) The District Appeals Committee will establish its own work procedures to the extent that they have not been established in this Law.

**18. Confidentiality**

A person who has obtained any information regarding a Mentally Disabled Person while carrying out his or her function, or in the course of his or her work pursuant to this Law will maintain the confidentiality of such information, will act in accordance with the provisions of any relevant law, and will not disclose such information other than for the purpose of carrying out the provisions of this Law.



**19. Information Services**

The Minister will take steps to provide accessible information services regarding all aspects of the rights established in this Law for the mentally disabled, including information regarding the Rehabilitation Services which are available to them and regarding those providing the services.

**20. Modification of the Rehabilitation Basket**

The Minister, upon consultation with the Minister of Finance, may, through the issuance of an order, add to the Rehabilitation Basket specified in the Supplement. The Minister may also, with the approval of the Knesset's Labor, Welfare and Health Committee, reduce what is included in the Rehabilitation Basket.

**21. Experimental Rehabilitation Services**

The Minister, or a party authorized for this purpose by the Minister, may approve the use of Rehabilitation Services which are not included in the Rehabilitation Basket, on an experimental basis, in order to determine their utility in terms of rehabilitation, provided that the total cost of their use does not exceed 5% of the annual rehabilitation budget established by law.

**22. Legal Jurisdiction**

A Regional Labor Court will have exclusive jurisdiction to adjudicate claims based on a legal ground arising from this Law.

**23. Budgeting**

The annual budget for rehabilitation of the mentally disabled in the community pursuant to this Law will be established in the framework of an allocation for a separate area of operations – the "Rehabilitation of the Mentally Disabled in the Community Law" budget item in the Ministry of Health budget within the annual budget law; for this purpose "area of operation" and "budget item" shall have the definitions given them in the annual budget law, as defined in the Budget Foundations Law 1985[8].

**24. Preservation of laws**

This Law will serve to add to the provisions of any existing law and will not detract from them.

**25. Execution and Regulations**

The Minister charged with the execution of this Law may enact regulations regarding all aspects of its execution, and with the approval of the Knesset's Labor, Welfare, and Health

[8] SH, 1985, p. 60.

Committee, the Minister may establish –

(1) Regarding the areas listed in the Supplement – the scope of the Rehabilitation Services to be given, and if a specific Rehabilitation Service is within a different minister's area of responsibility, the Minister will enact the regulations upon consultation with such other minister;

(2) Whether a specific Rehabilitation Service will be provided in exchange for payment, and the amount of the payment to be required and the manner in which it will be collected;

(3) That the Rehabilitation Services of certain types determined by the Minister will be provided by Rehabilitation Service providers who meet the criteria that the Minister has established;

(4) The work procedures of the Committees and their reporting requirements.

**26. Entry into Force**

This Law will enter into force at the end of six months from the date of its publication.

**Supplement**
(Rehabilitation Basket)
(Section Two)

**a. Employment**

Assistance in referral to and financing of the following Rehabilitation Services:

(1) Evaluation – a service regarding the evaluation of a mentally disabled person's current and potential ability;

(2) Professional Rehabilitation Center – a service providing diagnosis, work training and placement in an appropriate place of employment.

(3) Integration at work:

(a) A service that assists with integration into the open labor market as a salaried or self-employed worker;

(b) Supported employment – a service that assists with integration into supported rehabilitative employment in the open market;



(c) In a supported sheltered workplace – a rehabilitative employment service for those who are not able to be integrated into the open market;

(d) Occupational center – a pre-employment service which integrates social activities and the acquisition of life and employment skills.

**b. Housing**

(1) Assistance with referral to and the financing of accompaniment, training and supervisory services in the framework of independent and assisted living regarding the following types of housing:

(a) Independent housing – accompaniment by a professional aid worker or coach;

(b) Satellite housing - home visits, one to two days a week;

(c) Assisted living - home visits, three to five days a week;

(d) Augmented assisted living;

(e) Group homes;

(f) Group homes for youth;

(g) Reinforced group homes;

(h) All-inclusive group homes;

(2) Assistance with rental payments in the context of the forms of housing listed in paragraph (1);

(3) Assistance with rental payments in the context of assisted living;

(4) Assistance regarding the purchase of initial household equipment for private housing in the community;

(5) Assistance for community-based housing frameworks that are operated by non-profit organizations and private initiatives, for the purchase of initial household equipment.

**c. Adult education**

Assistance with referral to and financing of these services:

(1) Hebrew language classes (*ulpanim*) – Hebrew language classes for new immigrants, under special conditions;

(2) Completion of elementary school education – regular and special classes for the completion of elementary school education;

(3) Completion of high school education – regular and special classes for the completion of high school education;

(4) Computer studies – regular and special frameworks for computer education.

**d. Social activity and leisure**

Assistance with referral to and financing of social clubs in regular and special frameworks, for social activity and acquisition of social skills during leisure hours.

**e. Families**

(1) Counseling, training and guidance for families of the mentally disabled;

(2) Vacation housing – assistance with referral to and financing of short stays in the context of special assisted housing for the mentally disabled who are living with their families on a regular basis;

**f. Dental care**

Assistance with referral to and financing of dental care – preventative and proactive dental care, in accordance with criteria to be determined by the Minister.

**g. Coordination of treatment**

Appointment of a treatment coordinator who will be responsible for implementation and coordination of the provision of all the services provided to the Mentally Disabled Person.

Ehud Barak
Prime Minister and Acting Minister of Health

Avraham Burg
Acting President and Chairman of the Knesset



## List of Speakers

| | |
|---|---|
| **Prof. Alik Aviram,** | Scientific Director MIHP Organization |
| **Prof. Uri Aviram,** | Chairperson of Israel National Council for the Rehabilitation in the Community of Persons with Mental Disabilities. Professor. Emeritus, The Hebrew University of Jerusalem. |
| **Prof. Robert Drake,** | Andrew Thomson Professor of Psychiatry and Community and Family Medicine Dartmouth Medical School and Director of the Dartmouth Psychiatric Research Center. |
| **Prof. Yigal Ginath,** | Ben-Gurion University and The Hebrew University. Chairperson, Reut Community Mental Health Organization. |
| **Mrs. Tamar Goz'ansky,** | Former Member of the Knesseth. |
| **Dr. Michael Hogan,** | Commissioner of Mental Health, New York State. |
| **Prof. Moshe Kotler,** | Director, National Council for Mental Health. Director, Beer-Ya'acov Mental Health Center. |
| **Prof. Shlomo Kravetz,** | Professor. Emeritus Bar-Ilan University. |
| **Prof. David Roe,** | Head, Department of Community Mental Health University of Haifa. |
| **Prof. Eliahu Shamir,** | Professor Emeritus The Hebrew University and chairperson of "Ozma" Israeli forum of families of persons coping with mental illness. |
| **Mr. Yechiel Shereshevsky,** | National director for Mental Health Rehabilitation, Ministry of Health. |
| **Dr. Mike Slade,** | Reader in Health Services Research, Institute of Psychiatry, King's College London. |
| **Prof. Graham Thornicroft,** | Head of Health Service and Population Research Department, Institute of Psychiatry, King's College London. |

## *Prof. Alexander (Alik) Aviram*

Alik Aviram is MD from The Hebrew University – 1961. Specialist in Internal Medicine, Nephrology and Medical Management. Formerly head, Department of Nephrology and of Rokach ("Hadassah") Hospital, T.A .Associate Director – General of Hadassh Medical Organization, Jerusalem. Director – General of Assuta hospital, T.A. Medical Director, Maccabi health Services.

Currently Scientific Director, The Israel National Institute for Health Services and Health Policy Research.

## *Prof. Uri Aviram*

Uri Aviram is Zena Harman Professor Emeritus of Social Work at the Hebrew University of Jerusalem. Also serves as the chairperson of the Israel National Council for the Rehabilitation in the Community of Persons with Mental Disabilities. Formerly he headed the School of Social Work at Tel Aviv University and, during the 1990s, the School of Social Work and Social Welfare of the Hebrew University of Jerusalem. He also held positions at universities in other countries: Rutgers, Cornell, Case Western Reserve, Melbourne, Sydney and Berkeley.

His study areas include mental health policy and services research, social policy, law and psychiatry and community rehabilitation of persons suffering from mental disabilities. His books and articles were published in the US, Israel, and in international journals.



## *Prof. Robert E. Drake*

Robert E. Drake, MD, PhD is the Andrew Thomson Professor of Psychiatry and Community and Family Medicine at Dartmouth Medical School and the Director of the Dartmouth Psychiatric Research Center.

He was educated at Princeton, Duke, and Harvard Universities; he has at been Dartmouth for over 26 years. He continues to work actively as a community mental health doctor. He supervises a large number of students, post-doctoral trainees, and junior faculty.

His research focuses on people with serious mental illnesses and services that help their recovery, primarily in the areas of co-occurring disorders, vocational rehabilitation, health services research, and evidence-based practices. Current projects include developing and studying electronic decision support systems to enhance communications and shared decision making between clients and clinicians; randomized controlled trials of services for clients with first psychotic episodes and for clients with co-occurring substance use disorders; and interventions to help clients who want to quit smoking.
He has published more than 25 books and over 400 research articles.

## *Prof. Yigal Ginath*

Yigal Ginat, MD, is an Associate Professor of Psychiatry. He was graduated from The Hebrew University – Hadassah Medical School in Jerusalem in 1964. Psychiatric training 1967-1971 at the Talbieh Mental Health Center in Jerusalem. Underwent full psychoanalytic training at the Jerusalem Psychoanalytic Institute (1968-1975).

Prof. Ginath interest in Psychiatric Rehabilitation bought him to The Moudsley in 1982 where he spent a few months with Prof. Douglas Bennett.Prof. Ginath spent most of his professional career in the public system (1967-1997). For the last 15 years he acted as director of two Mental Health Centers (Beer Sheva, 1982-1988 and Talbieh 1988-1997).

In 1995 he established "Reut" an NGO for Rehabilitation of Mental Patients in the Community, supported at the beginning by Richmond Fellowship International and Joint Israel and serves as its chairperson up to now.For the last 10 years he directs a three years program in psychotherapy under the auspices of The Beer-Shiva University School of Medicine.

Prof. Ginath retired from the public service in 1997 and since then shares his professional activities between private practice, teaching and as a volunteer at Reut.

During his long career he was involved in the various developmental stages of Israeli Psychiatry, in training of young psychiatrists, establishing rehabilitation services, legislation and scientific projects.

## *Dr. Michael f. Hogan*

Michael Hogan has been Commissioner of Mental Health in New York since March 2007.

The NYS Office of Mental Health operates 25 accredited psychiatric hospitals, and oversees New York's $5B public mental health system that serves 650,000 individuals annually.

Dr. Hogan served as Director of the Ohio Department of Mental Health (1991-2007) and Commissioner of the Connecticut DMH from 1987-1991. He chaired the President's New Freedom Commission on Mental Health in 2002-2003, and was appointed as the first behavioral health representative on the board of The Joint Commission in 2007. He served (1994-1998) on NIMH's National Advisory Mental Health Council, as President of the National Association of State Mental Health Program Directors (2003-2005) and as Board President of NASMHPD's Research Institute (1989-2000).

He has received leadership awards from the National Governor's Association, the National Alliance on Mental Illness, the Campaign for Mental Health Reform, the American College of Mental Health Administration and the American Psychiatric Association.



He is a graduate of Cornell University, and earned a MS degree from the State University College in Brockport NY, and a Ph.D. from Syracuse University.

## *Prof. Moshe Kotler*

Moshe Kotler ,MD MHA, is currently the associate Dean for Medical Education at the Sackler Faculty of Medicine, Tel Aviv University. In addition, he is the Chairman of the Department of Medical Education as well as the Director of the Beer Yaakov-Ness Ziona Mental Health Center – the largest state psychiatric hospital in Israel. He also serves as the Chairman of the National Council for Mental Health in Israel.

Professor Kotler is a graduate of the Hadassah Medical School, Hebrew University (1974) and completed his psychiatry residency at the Shalvata Mental Health Center followed by a fellowship in biological psychiatry at the Albert Einstein College of Medicine, Bronx, New York.

He served for almost 2 decades in the Israel Defense Force (IDF) where he held the position as head of Mental Health Services with the rank of colonel. Following his honorable discharge from the IDF, he served as the Director of the Beer Sheba Mental Health Centre in Southern Israel where he also held the post of Vice Dean of the Faculty of Medicine at Ben Gurion University and the Jack Dreyfuss Chair of Psychiatry Research. At the Tel Aviv University, he served as the Chairman of the Department of Psychiatry and was promoted to Full Professor of Psychiatry at both Ben Gurion University and Tel Aviv University.

His principal focus of research is in the fields of PTSD and stress related conditions. He has published over 200 original research papers in medical journals as well as contributing numerous more chapters and review articles to the medical literature. For the past several years he has channeled his energies in academic pursuits in the field of medical education and was a member of the group that formulated new admission procedures and systems for the medical school.

## *Prof. Shlomo Kravetz*

Shlomo Kravetz, Ph.D., is Professor Emeritus in the Rehabilitation Psychology Program in the Department of Psychology at Bar-Ilan University, Israel.

After receiving a Bachelor of Science degree in psychology from the University of Pittsburgh, he immigrated to Israel where he received a Masters Degree in psychology from Bar-Ilan University. His first position as a psychologist was with Beit Loewenstein Hospital and Rehabilitation Center. The Human Service Scale, a multifaceted measure of rehabilitation status and outcome, was the topic of his doctoral studies.

After receiving his doctorate in rehabilitation psychology from the University of Wisconsin, he joined Professor Solly Katz's initiative in founding a Master's Degree program in rehabilitation psychology at Bar-Ilan University. A sabbatical with the University of Pittsburgh's Western Psychiatric Institute Clinic and Institute persuaded him to specialize in psychiatric rehabilitation and to join in Israel's recent multidisciplinary efforts to improve and expand the rehabilitation services provided to persons with severe mental illness. Thus, he became one of the original members of the National Council for the Rehabilitation of Psychiatric Disabled Persons in the Community. His research interests include psychiatric rehabilitation, integrating qualitative and quantitative research in psychiatric rehabilitation, the role that empathy and metacognition play in psychiatric rehabilitation, and the linking theories of motivation to the assessment of rehabilitation outcome



## *Prof. David Roe*

Associate professor, chair of the Department of Community Mental Health, Faculty of Social Welfare and Health Sciences at the University of Haifa, and an adjunct associate professor at the Department of Psychiatric Rehabilitation and Behavior Health Care, School of Health Related Professions, University of Medicine and Dentistry of New Jersey. He is also the initiator and director of the Center for Community Mental Health Research, Training, Services and Policy. After receiving a Bachelor of Arts degree (Magna Cum Laude) in psychology from Brown University he went on to Columbia University Teachers College where he received his Masters of Philosophy, Masters of Science and Ph.D. in Clinical Psychology. He was a post-doc fellow at the Institute for Health, Health Care Policy, and Aging Research, Rutgers University and a senior lecturer at Bar Ilan University.

His research focuses on the psychosocial processes of recovery from serious mental illness and the evaluation of psychiatric rehabilitation interventions and services. Dr. Roe's research has been funded by several local and international sources, including NIMH, The Israeli Ministry of Health, The Israel National Institute for Health policy and Health Services Research, the Israeli National Insurance Institution and the Tauber and Rich foundations. Dr. Roe has published over 100 peer reviewed journals and book chapters and co-authored two books. He serves as the deputy editor of the Israel Journal of Psychiatry and Related Sciences, associate editor of BMC Psychiatry and is on the editorial board of the Psychiatric Rehabilitation Journal, American Journal of Psychiatric Rehabilitation and the International Journal of Health and Disability-related Stigma.

Professor Roe serves on several committees including the Council for the Rehabilitation of Persons with a Psychiatric Disability in the Community, management committee of ISPRA (Israel Psychiatric Rehabilitation Association) and Masad Disabilities (The JDC-Government of Israel-Ruderman Family Foundation Strategic Partnership for People with Disabilities in Israel).

## *Prof. Eliahu Shamir*

Eli Shamir is an Emeritus Professor of Mathematics and Computer Science, [the Alfassa Chair in Computer Science] having been at the Hebrew University of Jerusalem for 45 years. Between the years 1963–1965 he was an assistant Professor at University of California Berkeley. Over the years he has held visiting positions at several universities and research centers in the USA and Europe.

Prof. Shamir published over 100 research articles and book chapters in several areas of Mathematics Computer Science and Computational Linguistics. In recent years he has published surveys and research papers on Mental Health issues and systems. He serves as chairperson of the NGO "OZMA – Israeli families of persons coping with mental illness" and he is also a member of several mental –health advisory–councils.

In 2009 he was awarded honorary citizenship of Jerusalem in recognition of his contributions to mental health and to academic development at the Hebrew University.

## *Yechiel Shereshevsky*

Yechiel Shereshevsky is the head of the psychosocial rehabilitation unit in Israel. He studied clinical psychology at the Hebrew University, Jerusalem, and for 20 years he worked in inpatient psychiatric settings and ambulatory care.

In 1993, he commenced at the Department of Mental Health Services in the Israeli Ministry of Health where he pioneered the development of the Department's psychiatric rehabilitation services. With the development of these services, Sharshevsky and others brought about a dramatic change in the Israeli public psychiatric system.



## *DR. Mike Slade*

Mike Slade is a Reader in Health Services Research at the Institute of Psychiatry, King's College London, and a Consultant Clinical Psychologist in South London.

His main research interests are recovery–focused and outcome–focused mental health services, user involvement in and influence on mental health services, staff–patient agreement on need, residential alternatives to in–patient services, and contributing to the development of clinically useable outcome measures, including the Camberwell Assessment of Need and the Threshold Assessment Grid.

Dr. Slade has written over 150 academic articles and 7 books. He co–authored Making Recovery a Reality (2008, free to download at www.scmh.org.uk), the most downloaded document ever published by the Sainsbury Centre for Mental Health. His most recent books are Personal Recovery and Mental Illness (published by Cambridge University Press, 2009) and 100 Ways to Support Recovery (2009, free to download at www. rethink.org/100ways).

## *Prof. Graham Thornicroft*

Graham Thornicroft is Professor of Community Psychiatry, and Head of the Health Service Research Department at the Institute of Psychiatry, King's College London. He is a Consultant Psychiatrist working in a community mental health team in South London, and is Director of Research and Development at the South London and Maudsley NHS Trust. He chaired the External Reference Group for the National Service Framework for Mental Health, a ten–year national mental health plan for England. His areas of expertise include: mental health needs assessment, the development of new outcome scales, cost–effectiveness evaluation of mental health treatments, stigma and discrimination, service user involvement in mental health research, and mental health services in low income countries.

Professor Thornicroft has authored and edited 23 books and over 280 peer–reviewed papers in the Web of Science.

## Steering Committee

Prof. Uri Aviram, Chairperson

Prof. Alik Aviram

Mrs. Ilana Belkind

Prof. Yigal Ginath

Mrs. Ziva Litvak

Mr. Avi Oren

Prof. David Roe

Mr. Yechiel Shereshevsky



## List of Participants

| | |
|---|---|
| Adiri Presiada | Enosh–The Israel Mental Health Sassociation and the National Council for the Rehabilitation in the Community of Persons with Mental Disabilities |
| Alfiah–Burstein Shira | Lishma Association |
| Aviram Alik | Israel National Institute for Health Policy Research |
| Aviram Uri | National Council for the Rehabilitation in the Community of Persons with Mental Disabilities and The Hebrew University of Jerusalem |
| Avrami Shirley | Center for Research and Information, The Knesset |
| Baloush–Kleinman Vered | Rehabilitation Dept., Mental Health Services, Ministry of Health |
| Baniel Tova | Rehabilitation Dept., Mental Health Services, Ministry of Health |
| Barak Dina | Rehabilitation Dept., Mental Health Services, Ministry of Health |
| Belkind Ilana | National Council for the Rehabilitation in the Community of Persons with Mental Disabilities |
| Benaroyo Elizabet | The Gertner Institute |
| Ben–Shitrit Ruth | Rehabilitation Dept., Mental Health Services, Ministry of Health |
| Cohen Benny | Yozma–Derech Halev |
| Derhy Oren | The Laszlo N. Tauber Family Foundation |
| Doron Haim | Israel National Institute for Health Policy Research |
| Drake Robert | Dartmouth Medical School and Dartmouth Psychiatric Research Center, USA |
| Dudai Ronit | Rehabilitation Dept., Mental Health Services, Ministry of Health |
| Fefferman Beni | Ministry of Industry, Trade and Labor |

| | |
|---|---|
| Gelkopf Mark | Deprt. Of Community Mental Health, University of Haifa |
| Ginath Yigaal | Ben Gurion University and Reut, NGO for Community Mental Health |
| Gozansky Tamar | Former Member of Knesseth |
| Hadas Hilla | Enosh – The Israel Mental Health Association |
| Hadas Lidor Noami | Department of Occupational Therapy, Tel Aviv University |
| Hasson-Ohayon Ilanit | Dept. of Psychology, Bar Ilan University and the National Council for the Rehabilitation in the Community of Persons with Mental Disabilities |
| Hogan Michael | New York State Office of Mental Health, USA |
| Horowitz Mira | Meuhedet Sick Fund |
| Kaidar Nir | Ministry of Health |
| Kaplan Giora | The Gertner Institute |
| Karny Nathan | Beer-Yaakov Mental Health Center |
| Kravetz Shlomo | Department of Psychology, Bar Ilan University |
| Kriel Sara | Rehabilitation Dept., Mental Health Services, Ministry of Health |
| Lachman Max | The Laszlo N. Tauber Family Foundation |
| Leidner Batya | Rehabilitation Dept., Mental Health Services, Ministry of Health |
| Levinson Dafna | Ministry of Health |
| Litvak Ziva | Israel National Institute for Health Policy Research |
| Majar Ayelet | Shalvata – Mental Health Center |
| Moran Galia | Deprt. Of Community Mental Health, University of Haifa |
| Naon Denise | Myers-JDC-Brookdale Inst. |
| Prior Rivka | National Insurance Institute |
| Rinott Gitit | Rehabilitation Dept., Mental Health Services, Ministry of Health |



| | |
|---|---|
| Roe David | Department of Community Mental Health, University of Haifa and The Natioanl Council for the Rehabilitation in the Community of Persons with mental Disabilities |
| Rosen Bruce | Myers-JDC-Brookdale Inst. |
| Rosner Itzhak | Social Services Department, Municipality of Haifa and the National Council for the Rehabilitation in the Community of Pesons with Mental Disabilities |
| Rothschild Sharon | Rehabilitation Dept., Mental Health Services, Ministry of Health |
| Rudnick Abraham | University of Westren Ontario, Canada |
| Sapir Vered | Rehabilitation Dept., Mental Health Services, Ministry of Health |
| Saragusti Idit | Bizchut – The Israel Human Rights Center for People with Disabilities |
| Shalev Anat | Beer Sheva Mental Health Center |
| Shamir Eliahu | Ozma- Israeli Families of Persons Coping with Mental Illness and The Hebrew University of Jerusalem |
| Shereshevsky Yechiel | Rehabilitation Dept., Mental Health Services, Ministry of Health |
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| Strous Israel | Beer-Yaakov Mental Health Center |
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| Weissbrem Padan Dana | The Moshe Hess Amuta |
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