Israel's Rehabilitation in the Community of Persons With Mental Disabilities Law: Challenges and Opportunities

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This column describes an innovative, government-sponsored, countrywide mental health reform focusing on rehabilitation and community integration of persons with serious mental illness, which was enacted into law in Israel in 2000. The reform was part of the country's efforts to shift the locus of treatment and care from psychiatric institutions to the community. The authors review preliminary evidence of the impact of reform and offer cautionary notes regarding the future direction of its implementation. The decade after the law's enactment saw an impressive increase in rehabilitation services, a significant reduction in the number of psychiatric beds, and major changes in government budget allocations. The authors examine factors that may endanger the viability of reform and discuss lessons to be learned from the Israeli experience. (*Psychiatric Services* 63:110–112, 2012; doi: 10.1176/appi.ps.201100009)

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Israel's Rehabilitation in the Community of Persons With Mental Disabilities Law (RMD) (1), which was enacted in 2000, is an important social law. It reflects progressive approaches to the care of persons with serious mental illness and makes a major contribution to the country's efforts to shift the locus of treatment and care from psychiatric institutions to the community (2). We believe that by international standards (3), this law represents an innovative and advanced approach to the care and treatment of persons with psychiatric disabilities (3,4), reflecting societal commitment to improve the quality of life of persons in this population and to facilitate their recovery process (5).

Major changes were implemented in the mental health service system in Israel (2) after the RMD law was passed. Provisions of the law are important components of planned comprehensive reform of the mental health system. Completion of the overall reform will include transfer of responsibility for inpatient and ambulatory mental health services to health care organizations (referred to below as "insurance reform"). Because this has not yet been achieved and because the components of mental health services are interrelated, it would be premature to pass judgment on long-term effects of the RMD law.

In this column, we describe an innovative, government-sponsored, countrywide reform of the mental health system focused on rehabilitation and community integration of persons with serious mental illness. We review the impact of reform and sound cautionary notes about the future direction of implementing this legislation. Although this column describes mental health reform in a specific country, we believe that the lessons learned may be relevant to other countries dealing with similar challenges.

The mental health rehabilitation law

The basic tenets of the RMD law are that persons are entitled to psychiatric rehabilitation services on the basis of defined eligibility criteria and a professional assessment of need. The RMD law was designed to advance rehabilitation and integration into the community of persons with psychiatric disabilities by providing them with an opportunity to achieve the maximum degree of functional independence and highest possible quality of life (1,5). The law entitles persons who are at least 18 years old to apply for psychiatric rehabilitation services, if they have obtained the professional opinion of a psychiatrist and if their level of medical disability

resulting from a mental disorder is 40% or higher on the basis of criteria of the Israel National Insurance Institute. Applicants must apply to a Regional Rehabilitation Committee, which is composed of three mental health professionals, to request rehabilitation services. Based on its professional assessment, this committee may approve various services from a package of services determined by the RMD law. These services are designed to help in key life domains, such as housing, employment, adult education, social and leisure time activities, assistance to family members, dental care, and case management.

The law established a National Council for the Rehabilitation in the Community of Persons With Mental Disabilities (referred to below as the National Council) whose task is to monitor the implementation of the law and advise the government on further development of the rehabilitation services. Any change in the service package requires the approval of the legislature.

Despite general trends in mental health reform to integrate and mainstream mental health services with other health and social services (2,5), the promoters of the RMD law chose an "exceptionalistic" approach, enacting a special law for persons with mental disabilities and not relying solely on general health and welfare laws. They took this approach in view of the stigma associated with mental illness and exclusionary attitudes of others. In accordance with progressive approaches to rehabilitation (3), the law clearly states that rehabilitation is community based.

Admittedly, without the leadership, commitment, and determination of a legislative member who initiated and led the legislative process, this law would have not been enacted; however, these efforts bore fruit due to a configuration of factors, including a coalition of interest groups and specific legislative and political circumstances, that were present at the time (2,5). Budget support for this legislation from the Ministry of Finance was also a critical factor in implementation of the RMD law. [More details about the legislative process and the challenges facing implementation efforts, including additional references, are available in an online appendix to this column at ps.psychiatryonline.org.]

Implementing the RMD law and changes in the mental health system

Implementation of the RMD law, or rehabilitation reform, has made a substantial contribution to government efforts to shift the locus of treatment and care from psychiatric institutions to the community (6–9). Over the course of a decade, the number of persons receiving rehabilitation services in the community increased fourfold, the government budget for mental health rehabilitation services in the community increased eightfold (at constant prices), and according to Ministry of Finance annual budget documents for the Ministry of Health, the proportion of funds for rehabilitation services increased from 4% to 25% of the government's total mental health budget. [Figures detailing these changes and others discussed in this section are available in the online appendix at ps.psychiatryonline.org.]

Rehabilitation reform has been an important factor facilitating other changes in the mental health service system. Between 1999 and 2009, the number of psychiatric beds in the country declined by 50%, from 1.0 to .5 per 1,000 of the population. It is not surprising that during the same period there were significant reductions in the length of stay and the number of inpatient days in psychiatric hospitals (2,6,7). It is reasonable to link the dramatic decrease in rates of psychiatric hospitalization to the rapid development and implementation of psychiatric rehabilitation services in the community. It is therefore likely that rehabilitation reform created substantial savings in the Ministry of Health budget.

Despite these changes and progress, several concerns should be raised. Even with the notable reduction in psychiatric beds and the decline in inpatient days, the budget for government mental hospitals (at constant prices) was not reduced (2), nor were any government psychiatric hospitals closed (2,6,7). This is in contrast to reports by other countries in which mental health reforms were implemented (10) and might explain why the law was supported by government psychiatric hospitals.

Current issues and challenges faced by reform

As rehabilitation reform enters its second decade of implementation, its future success is uncertain. In addition to facing other challenges, reform efforts are being threatened by attempts to make changes in the RMD law that would limit its basic principles (11). The Ministry of Finance has been trying to change the RMD law to avoid increased expenditures resulting from service demands by eligible persons. Furthermore, because components of the mental health service system are interrelated, the delays in enacting the insurance reform might adversely affect rehabilitation reform and hinder government efforts to achieve comprehensive mental health reform.

The rehabilitation service system must consider organizational changes. In a short period, the system has grown from a relatively small operation to a statewide agency, regulating hundreds of services throughout the country—both not-for-profit agencies and private, for-profit service providers. The scope of these new responsibilities requires major organizational changes.

As indicated by Israel's Comptroller General and the National Council, the rehabilitation administration lacks a useful database that would allow policy makers to make data-informed decisions (12). There is a need for ongoing, systematic data collection to enable the evaluation of the quality and impact of services provided (13). In addition, the expansion of case management services has been recommended, including development of up-to-date regulations and design of adequate responses to special demands of peripheral communities, such as those in rural areas (12,13).

Another important task for the rehabilitation system is to encourage and finance systematic research. Whereas priorities should be determined by the administration, it is crucial that the research be independent of the executive branch. Further-

more, a special effort should be made to improve the quality and quantity of researchers in the rehabilitation field.

Additional challenges pertain to the core of the operation of rehabilitation services. Such challenges are related to the population served, financial supports, the package of services rendered, and the personnel providing the services.

It is estimated that only 15%–20% of the eligible population is being served (2,14,15). Furthermore, many of those who are not yet in the system may represent more challenging population groups. Another pressing task is to determine why 25%–30% of persons who have successfully applied for psychiatric rehabilitation services have not used them (2,6,7,12).

For the first five years of the law's implementation, the annual increase in budget was based on a plan (2). However, in subsequent years, incremental additions were not based on a long-range plan and therefore did not take into consideration such variables as the changing nature of the population or variations in service costs by region of the country.

The planned mental health insurance reform (11) has raised concerns that as the responsibility for inpatient and ambulatory services is transferred to organizations providing general health care, the people who experience the most severe symptoms will be neglected because the organizations will focus on persons with less serious forms of mental illness. This, in turn, would adversely affect rehabilitation services. According to the planned insurance reform (11), budgets transferred to health care organizations to cover their additional responsibilities will not be specifically designated for psychiatric services. If spending on mental health care is left to the discretion of these providers, pressures by other medical specialties and other interests could direct funds away from mental health services, adversely affecting the scope and quality of services and potentially causing serious harm to rehabilitation services.

In addition, some issues are related to personnel considerations, ranging from the number of personnel needed to their tasks and training. The fact that rehabilitation service delivery has been completely privatized requires urgent arrangements for regulating and monitoring these services. The number of personnel currently involved in monitoring and control is far from sufficient (2,12).

One of the most problematic issues is related to the fact that the delivery of services is based solely on the private market, and there is a risk that the government will become captive to service providers. As the government endeavors to reduce costs, hardly any competition exists, and the government is rather limited in its power to demand high-level professional personnel, to sanction providers, and to effectively regulate the system

Finally, as Israel has reached the end of the first decade of rehabilitation reform, the package of services should be reevaluated, with a view to excluding services that may no longer be needed and including important others.

Conclusions

Enforcing legal entitlement of persons with psychiatric disabilities to a package of services and the provision of these services solely on the basis of professionals' decisions is indeed a progressive step toward the care and treatment of persons with serious mental illness. Important achievements have been made in the decade since enactment and implementation of the RMD law in Israel. An understanding of this legislation and its implementation may help other jurisdictions that are attempting to improve services for and the quality of life of persons with serious mental illness. Nevertheless, implementation of reform is still in process and continues to face obstacles. Because the first decade of implementing this legislation has recently ended, it is important to assess the system, identify where changes are required, and take effective action.

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