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On the Way to Psychiatric Reform in Israel: Notes for an Ideological and Scientific Debate

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Abstract: Israel has launched its program for Psychiatric Reform. However, the implementation of its three areas of action, as the Reform has been conceived thus far, is uneven. While the development of the rehabilitation component has progressed as planned, the one that refers to the insurance component remains stalled. The third one, dealing with de-hospitalization and community care, has advanced only in part. Although many of the issues related to the three components of the Reform, of a curative and rehabilitative nature, have been adequately addressed, some crucial aspects are still awaiting a more extensive discussion by all mental health stakeholders. This paper reviews some value-laden and scientific issues as well as strategic measures that are suggested to be taken into account in a forward-looking and democratic Reform. Examples of these issues are: the quest for equity, at the time when the poor population is increasing in the country; scientific issues (e.g., the application of epidemiological data in planning for community needs, training for community-based personnel), that if left aside bear the risk of undermining the depth of the Reform; and strategic measures, purported to recruit the support of professionals and the general public that is essential in a movement that thrives on inclusion and promotes community-based care.

Introduction

Israel is in the process of reforming its delivery of public psychiatric care. The reform includes three areas of action: 1. The insurance component. This implies that the Ministry of Health is committed to transfer the responsibility for the provision of psychiatric services to the four national health maintenance organizations (health insurers), and that the latter will establish a basket of mental health care services (1); 2. The structural component. This implies that the process of de-hospitalization will be accelerated and community-based care will be promoted; 3. The rehabilitation component. This entails the full implementation of a basket of psychiatric rehabilitation services mandated by new legislation, "Rehabilitation of Persons with Psychiatric Disabilities in the Community" (2). The insurance component of the Reform has still not been implemented, although it was approved by the government in 2003 (3). In contrast, the second and the third components are already being partially implemented (for a recent review with regard to the status of the Reform, see 4).

The purpose of this article, which discusses selected issues linked to all three components, is to deepen and expand the debate around the Psychiatric Reform (PR) in Israel and thus contribute to the pool of ideas broached with regard to the national policy on psychiatric care (5), its ideological basis (6) and the technical issues it entails (4, 7).

For ease of reading and discussion, the text is organized by domains that relate both to the content and the implementation of the PR. In our opinion, all or most issues discussed below deserved to be addressed by all stakeholders.

Psychiatric Reform and Equity

A range of basic values nourish and guide the Psychiatric Reform. (Note here that throughout the paper we use the term PR since it is under this term that the process is known, but we submit that the more fitting term is Mental Health Reform to encompass all the diverse areas of action it should embrace.) These values are: safeguarding human rights; humanizing care; promoting social inclusion and full citizenship; making quality of life a desirable intervention outcome; and equitable planning. Although the PR debate in Israel touches unevenly upon most of these values, equity is seldom or never considered (except

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for the Dead Sea Conference in 2002 where mental health had a limited participation). Yet, the relevance of equity to mental health care hardly needs discussion given the unequal distribution of wealth in Israel. Indeed, recent data show that economic disparities are increasing. While during the years 1990-2003 the two upper deciles of the population had a 3.4 and a 0.3 relative increase in their income, all other deciles experienced a decrease (8). As of today, 1,430,000 persons of the population in Israel are officially defined as poor, particularly children and the elderly (9), two vulnerable groups with regard to their mental health.

Is the equity issue foreign to mental health planning? Certainly not. Epidemiological studies have universally showed that rates of psychiatric disorders are inversely related to social class (10). An Israeli study also showed this (11). The problem is compounded by the fact that it is the low-income groups with high rates of need for mental health care that are culturally the most distant from the mental health services. Unless planners address this finding seriously, services in the new era of the PR will continue to under-serve the poor.

To respond to the socioeconomic based disparities in the risk of physical morbidity, disability and mortality and the inadequate allotment of resources (12) public health experts and the World Health Organization have argued that planning has to be equitable (13, 14). The pursuit of equity, and not of equality alone, implies a redistribution of resources. Concretely, that Israel's so-called "periphery" (the South and the North) and its minorities (e.g., the Bedouin) should receive a proportionally larger assignment of resources than better-off population groups. In some quarters this is known as positive discrimination or affirmative action.

At present, service supply in Israel is, generally, based on demand. What PR requires is planning based on needs. We submit that an epidemiological-based service model may be a more adequate template for such planning, since it expands the currently dominant clinical model by adding a population-based orientation (Table 1).

The development of both models requires applying the epidemiological data already available in Israel (16), or the data which can be extrapolated from the literature (17). (New data will soon become available upon completion of the national survey which forms part of the World Health Survey; see 18.) In addition, equitable planning requires devising appropriate service delivery and intervention models and allocating resources according to the special status and characteristics of the populations served.

Table 1. *Two Planning Models: the Clinical and the Epidemiological (adapted from 15)*

Clinical (individual) Service Model	Community (epidemiological) Service Model
Individual-oriented	Program-oriented
Demand-based	Need-based
Action initiated by consumer/family	Action initiated by consumer/family/ community and mental health professionals
Intervention: episodic	Intervention: continuous
Curative/rehabilitative	Includes mental health promotion and prevention
Often isolated	Integrated with other care sectors
Rarely has area of responsibility	Always has area of responsibility
Usually run by mental health professionals	Community participation
Rarely exploits all community resources	Exploits all community resources
Aims at improving individual's health	Aims at improving community / group health
Care outcomes are evaluated	Community state of health is regularly monitored and programs evaluated

An important point is that there can be no equitable planning unless the current "districting" or regionalization schemes are re-established (whether or not in the numbers proposed by the 1972 Tramer Plan; see 6). The current scheme of "one country, six districts" is poorly suited to planning on the basis of population needs. In practice, it risks constituting a prescription for inequitable planning.

Despite Israel's unfair economic development and the devastating impact it is producing on large sectors of the population, our mental health literature rarely discusses equity in the context of mental health care. Typical is a recent paper (19) that constitutes an important technical input into Israel's PR. The general purpose of this paper is to formulate better answers for determining staffing patterns in clinics. It does so, however, in line with the current ideological framework in decision-making which *de facto* ignores the values/issues of needs and equity. Such an approach might not proceed from a valueless scientific stand but from a value-laden stand which risks lending authoritative support to the current *status quo*, even if that is not what the authors intended. It must be admitted that no Israeli study has yet been conducted exploring the differential needs of, say, the populations in Sderot (in clusters 4-6, as defined by 20), Rahat (in clusters 1-2) or Omer (in cluster 19), all of them on Israel's southern periphery, nor on the best way to apply a comprehensive biopsychosocial approach to interventions (21). Until Israel produces locality-specific data capable of supporting an equity dimension in its PR, Israeli experts may profit from surveying the literature on underserved populations in other countries (for some well documented illustrations, see e.g., 22, 23).

Psychiatric Reform and Leadership

PR implies a major multidimensional change in the way mental health services are conceived, programmed and delivered, a change whose premises are both ideological and evidence-based. Ideology has often been the engine of the PR movement, while establishing its scientific basis followed. One could argue that the reform movement in Italy, led by Franco Basaglia, pivoted around ideology (24), while the planning of community-based care proposed by Thornicroft and Tansella (25) hinges on evidence-based criteria. Today, few will question the wisdom of applying criteria based on both domains simultaneously.

One of the implications of this bi-modal approach is that PR requires leaders who possess an extensive command of world scientific literature, and not just of the European scene (for example, 26, 27). PR is being promoted in other regions too, such as Latin America (28), where its leaders are strongly committed to its ideological basis, such as the humanization and democratization of care and the attempt to dismantle the mental hospital walls by bringing care up to the sufferers' doorstep.

This sort of leadership does exist in Israel among both professionals and non-professionals, and one of its tasks may be to infuse enthusiasm into the disparate constituencies that play a part in establishing and/or sustaining PR. What is entirely alien to any genuine PR movement is, in our opinion, the current dominance of the Ministry of Finance over the setting of planning parameters (e.g., whether a mental hospital is needed or not, what number of psychiatric beds are to be retained). Granted, the Ministry of Finance needs to understand what PR is trying to achieve for the benefit of the population, but its sole competence is, within the limits of the national budget, to make available the funds PR needs. The Ministry of Finance should see mental health as an investment, and not as an expense (29). As it stands today, the power wielded by the (super-) Ministry of Finance perverts PR, since its two pillars, science (entirely) and ideology (partially), do not come under the Ministry's purview. In addition, the Ministry's central involvement risks undermining the firm leadership required to guide the complex process of conceptualization, implementation and public education regarding the Psychiatric Reform.

Complexity of Psychiatric Reform

PR is a multidimensional movement encompassing at least the following spheres of action:

The Redirection of Resources. Traditionally, in Israel, as elsewhere, mental health resources have been directed to mental hospital care. Although some changes have taken place (4, 30), even today there is an asymmetry in the assignment of resources, with

hospitals still enjoying the largest proportion of the mental health budget (31). (Perhaps, there is no better illustration than to compare the salaries of mental hospital staff with those of community clinic staff.) Yet, the largest proportion of the burden of mental disorder, recognized and unrecognized, is in the community. Recall here that the largest proportion of the life of a person with severe and persistent mental disorder takes place in the community. Recall as well that in Israel during the last four years, at least 2,500 persons after a long period of psychiatric hospitalization have found a way of living in the community with the help of psychiatric rehabilitation interventions. This new reality constitutes an opportunity for the redistribution of resources; but, unfortunately, the budgets have not followed the patient.

Countries that have carried out PR have done so either partially (e.g., Spain) or completely (e.g., Sweden, which closed down all its mental hospitals). To compensate for the loss of psychiatric hospital beds, psychiatric inpatient admissions are shifted to general hospitals, either to specialized wards or to any suitable ward (32). In Israel this redirection of inpatient resources is lagging. In Europe, the proportion of beds in general hospitals varies by the country's income level. The proportions are 28%, 21%, 10% and 12% respectively for the high income, upper-middle income, lower middle, and low income countries according to the classification of the World Bank (33). All these proportions of beds in general hospitals are much higher than in Israel. Indeed, in Israel, by December 2001, there were 5,207 beds in mental hospitals and 263 in general hospitals, or 4.7%. The corresponding figures one year later were 5,182 and 257, or 4.8% (34). The gap in the proportions between Israel and the rest of Europe is overwhelming, including for the low income countries.

Humanizing Care and Promoting and Monitoring Human Rights. Good psychiatric care is possible only if embedded in a matrix of human rights (32, 35). In many countries, PR began when dictatorial regimes were replaced by democracies (e.g., Spain, Brazil). Of course, this is not the case in Israel. Yet, despite the country's democratic tradition it is only in recent years that there has been a rise in societal awareness of patients' rights (contrast 36 with 37). These human rights extend from access to care to the right to be informed about the course of treatment (38).

PR is nourished by a doctrine and practice that upholds both the rights of consumers and their caregivers. The reciprocal of this statement is no less valid: only a fully implemented PR can ensure that the human rights of persons with mental disorders and their families and caregivers will be safeguarded. Outdated service and planning modalities seldom meet these standards.

For PR the humanization of care is a defining goal. This implies, among other measures, giving full respect to people who need care; always promoting their autonomy; meeting needs with attention to cultural and gender differences; reducing the length of inpatient stays, offering in lieu well equipped community-based treatment modalities; and discouraging hospitalism-characteristic behavior, such as having the patients wear pajamas during the day or letting them endlessly pace the corridors for lack of creative activities during the daytime and evening.

Humanizing PR requires the continuous education of every single member of staff, professional and lay, and appointing mixed committees to periodically monitor observance of human rights. The tasks of these committees are better discharged if they include professionals, lay staff, and representatives of service users and their families. (Obviously, the latter too need to be educated about their rights.)

Improving Quality of Care. PR sets high standards of excellence in care with respect to both the comprehensiveness of intervention strategies and their scientific base. Accordingly, PR promotes the provision of evidence-based care. The latter not only includes evidence from psychopharmacological studies but also from psychological and socio-anthropological research. As mentioned above, epidemiological studies have shown that the socioeconomic status is inversely related to the prevalence of psychiatric disorder (10, 39), thus the representation of the poor is expected to be relatively high in the services. Saraceno and Barbui (40) noted that caring for a person with a psychiatric disorder requires addressing both the clinical component of the illness and issues or problems arising from their low socioeconomic status. In conclusion, an intervention that is not tailored to the full needs of the

person with a disorder risks failing to achieve the necessary outcome. The outcome sought by the interventions should not solely be the symptom remission but also an improvement in quality of life. Admittedly, the psychiatric services cannot be the sole provider of such a comprehensive intervention. Accordingly, they need to build close partnerships with other agencies (41). To achieve this, PR promotes close coordination at the local level between all relevant stakeholders (see Redirecting Training below).

Legislation. PR needs the sanction of the law to stimulate, guide and develop both current and new activities which are part of it (35). There is no doubt that Israel is making major strides in this regard (37). Thus a number of important laws have been passed and put into effect (Treatment of Mental Health Patient Act, 1991; National Health Insurance Act, 1995; Patient's Rights Act, 1996; Equal Opportunity for Disabled Persons Act, 1998; Rehabilitation of Mentally Handicapped Persons in the Community Act, 2000). Perhaps what is still lacking is a "master law" laying down the country's obligations with regard to mental health promotion, primary prevention and the financing of services. The inclusion of promotion and primary prevention and the corresponding funding is a necessary legislative element because the current view, that service provision is exclusively linked to curative action, defeats the spirit and doctrine of a well-conceived PR. The master law should also establish the principle of regional budgets, rather than allow capitation or "bed-linked budgetary assignment" to continue. Regional budgeting may facilitate equitable planning.

Including Service Consumers and their Families. PR is imbued with democratic principles, the involvement of all stakeholders, particularly of patients and families, should be required practice (see 6). The participation of service users and family organizations has ceased to be a rare event in the Israeli mental health scene. The two prestigious National Councils (on Mental Health and on Rehabilitation) include such representation. What needs to be buttressed today is the active and continuous participation of those two partners in every psychiatric setting (hospitals, clinics, hostels, etc.) and in a range of functions, including overall planning, priority setting, mental health education (of students and trainees), quality control, and human rights monitoring. Only when at both headquarters and field levels service users and family members are actively involved will we be able to say that PR has achieved full social inclusion.

Redirecting Training. To practice mental health in the community requires knowledge and skills that are not acquired in hospital-based training. A true PR responds to both the total population demands, as well as to the needs of those who do not apply for help to the mental health care services (42). This is a fundamental departure from the clinical model prevailing today, which is fostered by a patient-based insurance ideology. A European Psychiatry Association-sponsored meeting of the leaders of European psychiatry (Geneva, April 14, 2003) addressed the training needs of future psychiatrists with reference to community practice. The consensus statement issued at the meeting applies to Israel as much as anywhere. The mistaken conception is common among us — so it would seem, given the absence of concern about this issue as PR planning develops — that a psychiatrist who operates well in a hospital setting can do equally well in the community. Unless the proper training is provided, there is the risk that community-based mental health workers will merely transfer the shortcomings of mental hospital care to the community.

Working in the community demands, among other areas of competence, knowing how to arrive at a community diagnosis. This emerges from the need to plan rational data-based interventions in the community. It requires that the mental health worker, psychiatrists not excepted, be familiar with epidemiology and ethnography. At the other end of the spectrum of community-based actions, the mental health worker needs to know how to operate within a model (see above), in which the role of the specialized services is considerably wider and more complex than when they operate from a traditional mental health facility. This complexity emerges from the fact that PR, in addition to curative care and rehabilitation, includes the development of preventive and mental health promotion activities, an addition that de-

mands familiarity with and training in the relevant knowledge and skill domains.

Mental health agents need to take a lead in negotiating with other sectors, especially those outside the health care system. Involving other sectors in policy making, delegating and/or sharing responsibility for certain activities, setting up information networks, and establishing local advisory committees involving agencies from sectors other than mental health are some of the ways of building collaboration. Again, these skills need to be learned during training and can hardly be learned if training takes place solely or primarily in a psychiatric hospital context.

Consumers and families possess knowledge that is important for creating better practices and policies. That is why professionals need to learn how to engage in a frank and continuous dialogue with consumers and families and relate to them as equals. An interesting training program with this purpose has started in the Hebrew University in Jerusalem (43).

Mobilizing Society. PR seeks to promote cultural change. As a result of stigma and discriminatory practices, large segments of Israeli society still harbor the notion that persons with severe mental disorders need to be kept hospitalized and, on discharge, barred from social opportunities. PR, by proposing dehospitalization and community care (4, 5), constitutes a radical challenge to prevailing attitudes and practices. However, lack of support from the general population may block the PR's implementation. Indeed, the barriers could be so formidable that a potential success story of improved mental health care risks turning into a crushing failure.

The social mobilization required extends from the general public to media and religious leaders to major decision-makers, e.g., Knesset members, government officials and health providers. The media are not free from stigma, as many of their reports bear witness, while the health providers express their stigma by remaining ambivalent about adopting two of the three components of PR in Israel, namely, the insurance and the structural components.

Israel is advancing in the promotion of a cultural change quite considerably. A single example suffices to illustrate this. For the last few years mental health has "come out of the closet," particularly around the time of the Mental Health Week. Celebrating this week takes various forms, but all attempt to make citizens more aware of mental health and become less stigmatizing. These efforts, however, ought to be continuous and differentiated by target population, in line with the prevailing views on effective social marketing (44).

Mobilizing the Professionals. Many countries around the world have developed psychiatry without psychiatrists. This is not the case in Israel nor can it be the case with Israel's PR. Because of this, Israel's PR will not be fully realized until mental health workers and GPs and community nurses become militant supporters of the effort. PR, it must be admitted, although professionally satisfying in many of the countries or regions where it has been implemented, presents a constant challenge to the practice of mental health care. It makes considerable demands in terms of time, commitment, creativity and energy. The protective high walls of the mental hospital are no longer present. Health care providers cannot grant prolonged periods of hospitalization. To treat a patient at home can entail complex collaboration with, e.g., caregivers, neighbors, the GP, community leaders, and the police. Most of these agents figure less prominently in routine hospital-based care and so require less investment of time. Mobilizing the professionals who hesitate to support PR will be more successful if the current leadership of the mental health care system adds its weight to the effort, if the organizational framework is unambiguously and incisively defined, and if the salary incentives (not merely parity with hospital-based salaries) are fully clarified.

Extending the Care Network. PR recognizes that the specialist psychiatric services constitute only the topmost stratum of a pyramid of coexisting service resources, all but one of the strata sited within the community. It is a pyramid whose strata increase in specialization as one nears its peak, whereas coverage and ease of access expand towards its base. Although the strata can be fairly represented as a pyramid they seldom operate in partnership with each other (32). Epidemiological studies have shown that there is a considerable treatment gap in the community (defined as the difference between true

and untreated prevalence) (42), and that persons with a disorder seek help from a variety of agents, sometimes simultaneously. The clear implication is that the extended care network needs to be recognized by the community-based services and, to an extent, orchestrated by them. Importantly, an analogous strategy of coordination is required at the central level among the Ministries of Health, Welfare, Education, Housing and the Municipalities.

(a) The first stratum of the pyramid and the first agent of care is the person him/herself. He/she is the subject and object of care. Self-care is truly the very first level of care and one that offers the most primary possibility of intervention. The mental health services seldom recognize it and even less often invest efforts to strengthen it. One illustration of self-care is the choice an ex-addict makes when he or she avoids the companionship of current addicts or avoids visiting the drug-infested neighborhoods where addicts socialize or engage in their illicit behavior. It is, after all, physiological and psychosocial factors that are the chief causes of relapse. Examples of evidence-based self care would multiply if the mental health services were to research and then capitalize on the resource, which is often left only to lay persons to promote.

(b)The next level of care comprises the family and self-help groups. The family, once perceived, in the context of ongoing intra-family conflict, as seeking to scapegoat the member identified as a patient, is now regarded in a positive light in its predicaments, shortcomings and coping abilities (45). The psychoeducational programs for families of persons with schizophrenia is one successful illustration.

As for self-help groups, Alcoholics Anonymous is the most prominent and long-standing example of a lay organization that helps its members towards recovery.

(c) The next layer of the pyramid consists of the community agents, easily identifiable by simple ethnographic inquiry. These agents may have little or no formal mental health knowledge and yet provide a great deal of care. Informal mental health providers vary according to a community's mental health make-up and socio-cultural characteristics (e.g., for the Haredi community and other religious patients, see 46, 47). Typical community agents are religious leaders. These leaders are in contact with people undergoing crises, such as divorce, bereavement or episodes of domestic violence, that may be causing psychiatric disorder or triggering or aggravating an existing disorder. Religious leaders may successfully support the person facing such stressors and, when the need arises, recommend timely referral to the specialized services. This may take place provided that the mental health services have previously opened such avenues of consultation. Religious leaders may or may not give positive sanction to a person hesitating to consult the formal mental health services, thereby reducing or increasing the stigma attached to these services. Stigma also hinders the efforts to socially reintegrate a returning psychiatric inpatient. Again, religious leaders may act to reduce or affirm the stigma. Admittedly, the dialogue between formal and informal care providers is not always easy and mutual distrust may prevail, but this partnership is unavoidable when practicing community-based psychiatric care.

Another resource to be found in this same stratum of the pyramid is the faith or lay healers (48). The formal services should not leave care entirely in their hands but should attempt to liaise with them in such a way that persons not benefiting from their services are promptly referred to the specialists. Often, persons with a disorder may attend both the specialist services and the traditional healers; in the absence of a strategic alliance, the healer may undermine compliance with formal treatment.

Of course, there are other agents in the community of a still more unorthodox nature, such as hairdressers (49) and bartenders (50), who, although less known by specialist mental health workers, nevertheless fulfill important functions in areas such as mental health education and referral (hairdressers) and risk reduction (bartenders).

(d) The next level in the pyramid is constituted by the agents of the primary health care system. This includes general practitioners (51), nurses (52), and other health care staff based in primary care clinics providing, *in situ*, diagnosis, treatment and referral services for mental disorders. The insurance component of the PR that is promoted in Israel (7) should greatly facilitate the smoother operation of this layer

of mental health care, provided that the GPs command the proper set of attitudes, knowledge and skills to offer such a service and that the specialized personnel is readily available for consultation and support.

(e) The next stratum comprises the specialized community mental health services. These cover a wide array of settings staffed by mental health professionals and paraprofessionals, including clinics, community-based rehabilitation services (53), mobile crisis teams, therapeutic and residential supervised services, home help and support services, and community-based services for special populations (e.g., trauma victims, children and adolescents, and the elderly). To be effective these community services require close working links with general hospitals and/or mental hospitals. These links might include, for example, a two-way referral system with the general hospitals accepting patients for short-term care and referring patients who are to be discharged to the community-based service network. Community mental health services work best when all the services described above are closely interlinked, and include the community's informal care providers (32).

(f) The next stratum is made up of the general hospitals as providers of mental healthcare for acute episodes. There are a variety of service settings, psychiatric inpatient wards, psychiatric beds in general wards (rare in Israel, except for co-morbid physical and mental disorders) and emergency departments, and outpatient clinics. They may also provide some specialist services (for children, adolescents and the elderly). They have links with services caring for patients with physical co-morbidity. As noted earlier, the proportion of psychiatric beds available in general hospitals of Israel's total number of psychiatric beds is below the corresponding proportion in European countries of a comparable income level (30).

(g) The next stratum contains the non-community-based specialist services, among them, the mental hospitals. As noted above, in terms of finance and personnel they still constitute Israel's dominant treatment setting. Admittedly, some changes are taking place. For instance, the number of inpatient beds is falling, particularly as a result of the closure of private mental hospitals (4). Yet this stratum still captures most of the resources assigned to mental health and this is a serious barrier to developing alternative community-based resources. PR has to change this state of affairs since there is evidence that community-based treatment is associated with better outcomes than inpatient treatment and care. Research evidence also suggests that shorter stays in hospital are as effective as longer stays provided community-based care is readily available (32).

Conclusion

This paper discusses selected issues related to the Psychiatric Reform. Although the PR debate has been ongoing for some years, we believe that a much wider-ranging and more widely-informed debate still is needed among all stakeholders. This paper has dealt with issues that, in our opinion, the debate has either insufficiently covered or totally ignored. Other important themes which should also find a place in the debate, such as the treatment and care of substance abusers, the young, the elderly, minorities, new immigrants and foreign workers, have also not found a place in this paper, but not only in this one (e.g., 1). An informed debate among all stakeholders will help choose and define guiding values, and assist in designing and implementing the policy, programs and services that are part of the PR. It is our hope that this paper contributes in part to such a debate.

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Commentary

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The last months have seen the publication of several important discussions of the planned mental health reforms in Israel. Haver et al. (1) carefully reviewed the process whereby the mental health service adapted itself and responded to social and professional changes in the second half of the 20th century. It is important to stress that the process of reintegration of the chronic mentally ill into the community is symptomatic of the nascence of a social paradigm of a significance far beyond the field of mental health alone. The essence of this new paradigm is that the disabled ("ab-normal," "in-valid") will no longer be sent "beyond the pale," but that society is responding to the challenge to contain them and give them equal status to the non-disabled ("normal," "valid"). The line that separates the abnormal and the normal is becoming increasingly blurred. Society is losing the disabled as its negative yardstick, since they are no

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longer untouchables. Society will have to find a new yardstick that will require the formulation of a new ethical position.

In this sense, the integration of the mentally ill may be seen as a symptom and a form of spearhead of the process of the restoration of other disabled back into society. Indeed, Foucault (2) declared that prisons were modelled on psychiatric hospitals, while the process of deinstitutionalization of mental hospitals that began in the 1950s is also happening in other institutions that care for the disabled.

So far, the theory. The actual process, however, is lengthy, exhausting and involves complex long-term changes in structure, administration and perception. While Haver et al. (1) declare good intentions concerning the necessary changes in the structure of mental health care in Israel, there have been a series of failures and political and administrative delays, causing a slowdown of the application of the theory.

A month later, Gil discussed the clinical and ethical problems that have arisen out of the reform (3). Gil presents the well-known misgivings of the health insurance companies, who perceive mental health care as an intolerable burden, and, worse still, as a sentence of death for the insurers. This reticence is understandable in relation to the theory of insurance: the insurer seeks to restrict the range of uncertainty by increasing the control over patterns of use of care by the insured, in order to assure maximum profits. Such an aim is sufficiently complicated and problematic in the field of general health care — how much more so in the case of the responsibility of the insurer in mental health care. The policymakers view the consumer community with great suspicion and seek to restrict the treatment alternatives in order to control demand. Such an approach may bring about solutions that are feasible possibly for the insurer but blatantly unacceptable for the patient. Some examples: an administrator-supervisor who is a professional, whose task is to permit or refuse the request of a patient for psychiatric care, its cost, its duration, according to parameters fixed by the insurer. Such an approach limits and may even truncate the range of therapeutic gain that the sufferer seeks. Another variation: the policymakers divide the consumers into two categories: "soft" psychiatry carried out by family practitioners including anxiety, depression and life-crises, while psychiatrists treat the "really" sick with "hard" psychiatry. This somewhat naive division represents a regressive trend compromising the quality of care: from our own experience in Israel we are aware that family practitioners have neither the training nor the framework necessary for a satisfactory therapeutic response. Further, the division into psychiatry soft and hard revives the stigmatic differentiation between the mentally ill and the "healthy," a tragic reversal of the policy of integration described above. Gil concludes: "This present review finds basis for the concerns that the transfer of responsibility for mental health care to sick funds will result in a deterioration of care received by those insured" (3).

Levav and Lachman's paper published in this issue is both surprising and courageous in that it identifies the weaknesses and even the failings of the proposed reform, both from an ideological and scientific viewpoint. They state that the reform must ensure three basic social values: maintenance of patients' rights, humane care and encouragement of social equality. They proceed to demonstrate the serious inequalities that exist at present in the organization and accessibility of the mental health services.

To the best of our knowledge, not only have no clinics been set up in areas of disadvantage based on sociodemographic data, but no evaluations have been carried out of the needs of the population in such areas. For example, in the area of physical health care there are authorities that undertake the planning of treatment facilities based on evaluations, polling of therapists, satisfaction questionnaires of patients, etc. At the same time, the enactment of any recommended changes is monitored by measures of quality assurance, formulating clinical guidelines, all in order to improve the therapeutic response to the ill and make the system more efficient.

What is to prevent the adoption of these same measures in mental health? The inexplicable avoidance of applying this approach to mental health impacts on planning, and continues the status quo of psychiatry "beyond the pale." We would like to mention that of late the committee for the planning of mental health services (the National Council for Mental Health), chaired by Professor Avner Elizur, has been active, and we hope its recommendations will be heeded by the policymakers.

Levav and Lachman claim that there has been no attitudinal change among mental health professionals that should serve to inform, unite and motivate those who will be called upon to enact the reform. Indeed, not only have the professionals not been active participants in the decision process, but they are quite unaware of what awaits them, both professionally and personally. This cannot be described as resistance to change for the simple reason that it is unclear what changes will occur, what will be the framework or the timetable.

Finally, the authors raise issues such as human rights, improving the quality of care, contact with families, professional supervision and training, which are discussed by Gil (3). There is real reason for concern — it seems that the projected reform will not develop and strengthen these values, but they will be perceived as stumbling-blocks en route to making the service more efficient. Yet we know too well that it is these values that are the branch on which rests community mental health care, and woe betide he who seeks to cut it off.

These would appear to be the real reasons for the standstill in the transfer of the insurance reform to the sick funds. There is undoubted moral value in including mental disorders in the insurance policies for physical illness. But here the comparison ends — practically treatment in mental health is critically different from somatic disorders. The proposed reforms do not appear to provide the necessary framework or conditions for mental health care suited to the social and professional conditions of our times.

Haver et al. conclude: "There remain unresolved a number of central issues, such as the final target for the rate of beds per 1,000 population, the number and type of beds per institution, the replanning of manpower, the method of selection of manpower from the hospital system for the community services etc…." (1)

I would like to conclude with the hope that if the conditions described by Levav and Lachman were fulfilled, and the concerns raised by Gil were dealt with, the issues delaying the reform raised by Haver et al. would be resolved.

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Commentary

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The directors of the psychiatric hospitals in Israel have been active participants in devising the guidelines for the new policy of psychiatric reform, and are committed to its implementation in the areas under their responsibility. This includes, mainly, the structural component (1). The goal of massive reduction in hospital psychiatric beds to 3,500 during the last four years has been achieved. On the other hand, this article and the actual situation show that parts of the reform remain unfulfilled:

The insurance component. This implies the transfer of responsibility for the provision of psychiatric services from the Ministry of Health to the health insurance organizations (Kupot Holim) and establish-

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ment of a mental health care package. Despite the government decision of June 26th, 2003, regarding this subject, so far nothing has been accomplished. The managers of the psychiatric hospitals consider this component essential for the success of the reform, and for the termination of the unjust situation of discrimination between mental and physical patients.

The structural component. An essential component of the reform is the rechanneling of funds saved from the massive reduction in hospital beds towards the development of ambulatory and community psychiatric services. Today any such development is "frozen," according to instructions from the Treasury.

The community psychiatric rehabilitation component. This legislation made the structural reform possible, but is dependent on a specific budget for further development of services in the community. In order to enable a real integration of psychiatric patients in the community there is a need of founding educational antistigmatic programs aimed at the general public, primary care services personnel, regional and governmental authorities, etc.The programs will focus on the psycho-bio-social aspects of the psychiatric disorders. A successful reform is not about saving money. The appropriate treatment in the community of thousands of mental patients released from hospitals requires a higher budget than the present one.

The approach of the Treasury to the reform as a budget-saving mechanism is likely to result in severe deterioration of mental health care in Israel. In order to prevent this, there should be criteria for assessing the results of the reform.

Though thousands of patients have already been discharged to the community following extended hospitalization, there is no available data of suicidal events, crime, homelessness and mortality. There is no data on the number of prison beds "replacing" hospital beds, neither is there data on the attitude of patients and their families regarding the changes in their lives (2-4).

This article discusses the need for equity in the allocation of resources. Israel's periphery should receive a larger assignment of resources as its population is much poorer than the central population. This so-called "positive discrimination" is of great importance, but as long as there are no well defined criteria for its execution, it is likely to remain unimplemented.

This article discusses the intention to integrate psychiatric hospitals with general medical centers (5).

This integration may improve the medical services for the patients, and decrease the social stigma associated with hospitalization in mental hospitals. It is still essential that the psychiatric hospitals retain their professional and financial autonomy, otherwise their limited resources may be used to provide the endless needs and pressures of general hospitals.

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Commentary: Obstacles to Reform of Mental Health Systems: Funding, Fragmentation and Fanaticism

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Reform of mental health systems is a complex task. Advocates driving the process rarely obtain the degree of change to which they aspire, and unanticipated negative consequences seem all but unavoidable. As Israel finds itself in a period of intense reform, described in the article by Levav and Lachman in this issue, it may be helpful to reflect not only on the philosophical and practical goals of reform, but also on the obstacles that may arise to frustrate the process. I offer the following thoughts based on my observations of attempts at transforming the mental health system in the United States; my Israeli colleagues will have to judge for themselves whether these concerns ring true in Israel.

Let me underscore that I take no position on either the plans for reform in Israel or how they are being (or not being) implemented. It would be foolhardy for someone as distant from the scene of the action as I am to opine on such things. However, at the risk of oversimplification, and without even pretending to be exhaustive, I would suggest that three of the roadblocks to effective change in mental health systems that arise time and again — regardless of venue — relate to funding, fragmentation and fanaticism.

When reforms founder, the absence of adequate funding for services is often a key reason why. In part, responsibility for the lack of funds to transition services from an inpatient-based to a community-based system (the usual goal of reform efforts) lies with the promoters of the reforms themselves. Looking at the costs of maintaining hundreds or thousands of beds in public psychiatric hospitals, reformers often generate support by arguing that the savings from facility closures will be enough to pay for the development of a community-based system of care. Unfortunately, that seems never to be the case.

Since community systems must be created before patients are transitioned in large numbers — and hence before savings are evident from reductions in inpatient beds — additional funding is always required if patients are not simply to be abandoned to the streets (as so often happened in the United States). Indeed, it may be many years before enough patients have left the hospitals that facilities can actually be closed, which is the only way to effect major cost savings. Reductions of beds, closures of individual wards, and other incremental reductions in inpatient services have only minor savings associated with them. So any legislator who supports a reform proposal on the basis that it will be self-funding from the start is bound to be disappointed.

Moreover, even in the long run, the projected cost savings are difficult to realize. Inpatient facilities remain open because the most severely ill patients are harder than anticipated to transition to community residences, and because general hospital psychiatric units are frequently incapable of dealing with or unwilling to handle highly disruptive patients who may need extended inpatient stays. Political considerations also come into play, since large inpatient facilities often provide a significant numbers of jobs to their communities, and closures may be opposed by politicians, unions and local civic groups.

Even when successful movement of patients to community-based care occurs, the bill for the mental health system continues to rise. Providing the full array of services that patients receive in hospital settings when they are living in group residences scattered through the community is, in many ways, a more expensive proposition than offering services at

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a single inpatient site. Costs of periodic rehospitalizations, which are inevitable with severely ill patients, are frequently omitted when community care expenses are projected. And treatment in general hospital psychiatric units — given the overhead general hospitals must support — costs more than comparable stays in specialty psychiatric facilities. Meanwhile, the introduction of new medications, therapies, and other technologies continues to drive costs upward.

Although there are few uncontroversial statements that can be made about the consequences of "deinstitutionalization" in the United States, I think it is fair to say that no jurisdiction saw total costs decline as a result of the effort. Indeed, the major driver for states to move patients to the community (a process that continues even today) was the availability of federal funding for their support (e.g., through the Social Security Disability system) and for their treatment (i.e., through Medicaid, a joint federal-state health insurance program). In the end, the taxpayers have paid more for the new system of care. That doesn't mean that the development of community-based services is unjustifiable; cost is hardly the ultimate determinant of the value of human service programs. But it does mean that the public must be prepared to pay more — not less — for an adequate system of care in the community.

When political leaders realize that reform of mental health systems is likely to mean increased costs, they often become less enthusiastic about the reform agenda. Unfortunately, that may not lead to a slowing of patients' discharge to the community — once set in motion, the process is difficult to stop. But it does imply that the services on which advocates were counting to support patients in their new settings may simply not materialize. And even politicians, who acknowledge the desirability of spending additional funds on mental health services for the sake of a modern community-based system of care, may lose interest over time as competing needs come to the fore.

If insufficient funding is the first hurdle that mental health system reform must overcome, fragmentation of the nascent community-based system is close behind. In long-stay public psychiatric hospitals, all services — housing, psychiatric treatment, general medical care and rehabilitation — are the responsibility of a single entity. The services may be provided well or poorly, but there's no question as to the accountable authority. Once patients are transitioned to the community, however, there is often no one to assume this integrative function.

Housing may be provided by an agency more concerned with maintaining the calm and cleanliness of its facility than in supporting a problematic resident through difficult times. Contact between agency staff and treaters, who can provide advice on dealing with patients' behaviors, may be minimal or may simply not occur. Rehabilitation services can be lodged in different entities than psychiatric treatment *per se*, with different goals and timetables, and an absence of coordination between the two. General medical care often falls between the cracks entirely, since persons with chronic mental illnesses are not considered desirable patients by most non-psychiatric physicians, and it is no one's particular task to ensure that they receive needed medical or dental care. High rates of comorbidity of mental disorders and substance abuse are belied by the frequent segregation of treatment services for these conditions, as if they were not intimately linked to each other.

Coordination of community-based care takes time, and time costs money. Moreover, the fragmentation of services in different public and private agencies usually means that none of them are given incentives to provide overall coordination — or even to work with one another. In the U.S., a variety of approaches has been tried to overcome this problem, including blending funding streams for housing, treatment, and rehabilitation, and putting them under the authority of a single agency. But the desire to retain control of one's funds and prerogatives is a powerful bureaucratic motivator; unless driven by outside forces, these efforts tend to fade over time. However, for community-based care to mean something more than just housing patients in the community, that is, for it to constitute a truly effective approach to dealing with the consequences of mental illnesses, fragmentation of services is a problem that must be solved.

Finally, a word about fanaticism. Efforts at mental health system reform often evolve into "movements," driven by what might generously be called philosophies, or what less charitably might be termed ideologies. Manichean tendencies abound. Thus, if

community-based systems are good, then they are good for everyone, regardless of the severity of their conditions or their particular treatment needs. And if community-based care is desirable, then hospital-based care is not, and the facilities that provide such care are not merely to become less prominent — they must be destroyed. This kind of thinking is fed by simplistic notions about the role of hospitals and popular demonization of the people who work in them (think *One Flew Over the Cuckoo's Nest*).

Such fanaticism is destructive of mental health system reform and harmful to patients because it denies the complexity of human needs by suggesting that there is only one acceptable approach to providing for persons with serious mental illnesses. When these tendencies become ascendant in a reform initiative, professional staff members become demoralized, families of patients are alienated and necessary compromises cannot be made. Perhaps equally significantly, as it becomes apparent that one or another initiative is not working as anticipated, alterations of plans are resisted as something akin to counter-revolutionary activity. Empiricism, not ideology, should drive human services. Ideologues need to be contained and neutralized if reform is to be successful.

I underscore that these observations derive from several decades of observing mental health system reform in the United States, and having some passing familiarity with efforts elsewhere in the world. It may be that things will evolve very differently in Israel. To paraphrase the *tanna* Rabbi Tarfon, the day is short, the task is great, and the reward can be large — but the obstacles to success are real and must be addressed.