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Challenges for Israeli Mental Health Law in the Next Decade

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Abstract: There are two major forces currently impinging on Israeli Mental Health Law in the civil field. One derives from the shift in public funding for Mental Health. The other is driven by the conviction that neither patient rights nor public needs are well served by current arrangements. The challenge for the next decade is how to respond constructively to these somewhat different, yet coalescing demands. The U.S. was subject to the same pressures and adopted "deinstitutionalization." Its practice fell far short of its promise, and in turn prompted other innovations to be adopted, principally Assertive Community Treatment and Assisted Outpatient Treatment. For these to focus on the correct population new risk assessment techniques were required and an actuarial approach was adopted. When this experience is applied to the Israeli context, three main elements emerge as necessary for a successful response to the challenges of the decade: (i) an effective mechanism for risk assessment in mental health, (ii) substantially expanded research and professional training infrastructure in forensic mental health, and (iii) changes in the attitude towards the mentally ill and their treatment.

Introduction

There are two major forces currently impinging on Israeli Mental Health Law in the civil field. One derives from the shift in public funding for Mental Health. The other is driven by the conviction that neither patient rights nor public needs are well served by current arrangements. The challenge for the next decade is how to respond constructively to these somewhat different, yet coalescing demands.

The following section will describe each of these two forces that challenge the Israeli Mental Health System. Section III will describe the experience of the United States, as it strove to deal with a similar set of problems. The presumption here is that this experience might be a useful precedent for Israel, both in terms of possible solutions and in order to avoid repeating mistakes. The last section of the paper lays out the three main elements that emerge as necessary for a successful response to the challenges of the decade.

The Forces Challenging the System

There are two main forces currently impinging upon the Mental Health System of Israel:

1. Shift in funding: the budgeters of the Ministry of Finance are cutting spending on inpatient mental health facilities, while within the community not enough ambulatory services are being opened and the sick funds are not correspondingly expanding coverage of mental health care in the communities; and,
2. Scholars, the courts and assorted members of the legal community all claim that current arrangements are simultaneously unfair to patients and ineffective in accomplishing public policy goals in Mental Health.

Let us examine each in turn.

(1) Public finance considerations lead to the discharge of patients into the community

The fiscal arithmetic is simple: discharging patients into the community saves money because, at a minimum, you save the "hotel" costs associated with long-term hospitalization. Fortunately for the budget cutters, a tool for their purposes was available: the "Rehabilitation of Mentally Handicapped within the Community Law" — (2000) — RMHCL (1). This legislation had originated quite independently in the legitimate concern of legislators to create an ad-

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vanced and progressive framework of supporting services and programs within the community that facilitates the return of patients from psychiatric hospitals into mainstream life (2, 3). Once on the books, this law cleared the way for the Health Ministry and the Finance Ministry to push for a shift from hospital-based psychiatry to community-based psychiatry.

Implementation has had several implications. The first is a reduction in the size of the psychiatric hospital system by downsizing some of the hospitals and substantially decreasing the number of psychiatric beds in others (2). Some of the money saved thereby was originally intended by the planners to fund new community services and programs for the mentally disabled. A second implication became known as "Insurance Reform," and consists of the shift of responsibility for treatment of the mentally disabled from the State to Sick Funds. This shift in responsibilities meant that the mentally disabled became entitled to benefit from the National Health Insurance Law (4) and to receive treatment, like any physically ill patient, in medical clinics spread throughout the community and operated by Sick Funds (3).

Today, nearly six years after the RMHCL was legislated, neither of the two major expected consequences has been fully realized. First, although there has been a substantial decrease in the number of psychiatric hospital beds, from 5,589 beds in 2000 to 3,500 beds at the end of 2005, insufficient resources have been directed to the community for psychiatric care to provide an adequate community counterpart (2, 5). This has created a deficiency in community ambulatory services (6) that can lead to homelessness and rehospitalization of patients who need treatment unavailable in the community. In this context it is interesting to note that the only field which improved during these years has been the rehabilitation field (6). Second, "insurance reform" is not yet implemented due to insufficient funding. For instance, in 2002, the Ministry of Health budget was lacking 170 million shekels to initiate the "insurance reform" (3). The fact that psychiatric patients cannot receive necessary treatment within the Sick Fund clinics serves to increase the need for psychiatric treatment facilities within the community (6).

(2) The movement for reform of the 1991 Treatment of Mental Patients Law (TMPL) (7)

The enactment of the 1992 Basic Law: Human Dignity and Liberty, reinforced the increasing tendency of courts to review decisions made by public agencies concerning matters of individual rights protected by the law (8–10). Among these was the role of the District Psychiatrists, who, operating under the Treatment of Mental Patients Law — "TMPL" (1991), were essentially deciding matters of personal freedom as they made recommendations for involuntary commitment (11–13). Accordingly, the courts became increasingly critical of decisions related to civil commitment. For example, the courts ruled that the Psychiatric Committees have to comply with the Doctrine of Natural Justice, and to construct their decisions on objectivity and plausibility (13–15). The courts also ruled that the law has to comply with the Doctrine of Least Restrictive Environment (16). The courts also ruled that the patient has the right, if he or she so wishes, to be represented by a lawyer (17).

The TMPL also came in for criticism from other major stakeholders. **Legal scholars** argued that the TMPL has broadened the commitment criterion that existed in the previous law without changing the commitment model from a medical to a legal one. The main distinction between the models is that in a medical model, commitment is decided by a psychiatrist on the grounds of need for treatment; in a legal model, commitment is decided by a Court on the basis of balancing personal freedom with the public interest of the safety of the community and the benefits of the treatment to the patient (17, 18). Members of the **Legal Community** have offered suggestions for solving some of the TMPL's problems, for instance: a committee headed by the Attorney General of the Central District recommended establishing new rules for the duties and powers given by the TMPL to the District Psychiatrist (19); a study was conducted by the Jerusalem Public Defender to assess the effectiveness of representation of the patients by a lawyer in civil commitment procedures held by the Psychiatric Committee (20). Eventually this, along with other forces such as an appeal to the Supreme Court and awareness of some Members of Parliament brought about the amendment of the

TMPL in 2004 and adopted section 29A which requires representation for every patient facing civil commitment. **The Association for Civil Rights in Israel** has directed criticism to both substantive and procedural measures derived from operating the TMPL (21, 22). **The State Comptroller** has criticized the extent of authority given to psychiatrists by the TMPL (23). Some psychiatrists within the **psychiatric community** directed criticism towards the TMPL (24). For instance, Dr. Yair Bar-El, who served as the Jerusalem District psychiatrist for 27 years, expressed his view that the powers of the District Psychiatrist should be narrowed and given to the Psychiatric Committee or even to the courts (25), while **others** in the **psychiatric community**, such as Dr. Moshe Kalian, the District Psychiatrist of the Central Region, defended the TMPL, claiming that over-involvement of the legal system in the commitment process will fail it (26). **Members of patients' families** also opposed the suggested changes. For them a change that might result in narrowing the commitment criteria and replicating the medical way of thinking with a legal one is not an option (27). Finally, as a consequence of this criticism, and especially the criticism from the courts, the **Chairman of the Israeli Psychiatric Association**, Dr. Michael Schneidman, and the **Israeli Medical Association** promoted a proposal to embrace the legal model and therefore to abolish the TMPL altogether (26).

There is no doubt that there is increasing discomfort and dissatisfaction with the TMPL from all major "payers" as well as players in the Israeli mental health system. This dissatisfaction, coupled with the shift to community-based psychiatry, may create the right atmosphere for a change in the law. The most significant future challenge for the Israeli Mental Health Law is to enhance patients' rights and well-being without interfering with the powers of the state to use coercion for treatment and prevention in cases of emergency. Adopting a form of the legal model could move decisions about treatment away from the district psychiatrists and into the courts.

It is very interesting to note that similar forces shaped changes in U.S. law.

"It has happened before": The U.S. experience as a precedent

There are three main topics to be discussed in relation to the American experience:

1. What happened and what it might predict for developments in Israel;
2. New responses to the disappointment with deinstitutionalization: ACT, AOT;
3. The new ingredient in the new U.S. responses: actuarial risk predictors.

Let us review each of these in turn.

(1) What happened and what it might predict for Israel

Four decades ago, the U.S. experienced criticism of psychiatric practice, an increased awareness of patients' rights, and the discharge of the vast majority of patients from psychiatric institutions into the community ("deinstitutionalization"). Changes in law were the result of the acceptance of a variety of procedural safeguards and the shift of power to coerce from psychiatrists to the courts. While impressive, these changes did not fulfill the promise of better care and management of the mentally disabled. A very comprehensive piece of research, conducted more than a decade ago, concluded that such changes did not substantially affect the characteristics of the committed population nor the care with which commitment decisions were made (28). Furthermore, there have been recent growing concerns among the American public regarding the danger that these "former" patients pose to society. These concerns translate to an erosion of the original legal model by both an increasing tendency to broaden the existing civil commitment arrangements for inpatient hospitalization which meant increasing the number of patients hospitalized, and accepting new statutes to provide outpatient treatment for people who suffer from mental disability (29).

The experience of the U.S. may give us a plausible indication of the effects of the forces that are now molding the Israeli Mental Health Law. Changing both the civil commitment model and the practice of discharging patients into the community might change the existing equilibrium. The discretion to commit patients will be transferred to the court. This

shift would mean an emphasis both on patient rights and procedural safeguards, which could decrease the number of civil commitments in which there is doubt concerning the necessity of commitment. Change in commitment models and discharging patients may also result in a massive growth of the population of mentally ill persons residing within the community.

This problem has different dimensions for inpatient and outpatient arenas. In the inpatient arena, implementation of a legal model would shift the emphasis from the medical viewpoint, which looks to promote the patient's mental health and well-being, to the legal viewpoint, which looks primarily towards minimizing encroachment on the patient's rights and freedom. Surprisingly, the fact that a strict scrutiny will be employed by the courts might actually result in loosening the commitment criteria. That could be accomplished by accepting a broader definition of mental abnormality and by broadening the definitions of danger to self and others in a way that allows treatment of patients who are badly in need.

In the outpatient arena, the dominant change is that of shifting to a community-based psychiatry. The American experience has taught us that, without building an adequate infrastructure and allocating the needed resources, the outcome of this shift can be devastating (28). Homelessness is one effect (30). Another is criminalization of the mentally ill, who commit illness-related offenses within the community and are sent to be punished by the criminal justice system instead of receiving needed treatment (31, 32). Patients may also "fall between the cracks" due to lack of treatment and inadequate follow-up (30). Finally, there is the "revolving door" phenomenon, in which patients who do not receive adequate treatment within the community are periodically hospitalized (28). The American experience has also demonstrated that while building an adequate infrastructure and allocating needed resources are crucial conditions, they are not sufficient. When patients refuse treatment and medication it is often illness-related (33). Therefore, in order to create an effective community-based system, infrastructure and resources are not enough. The legal system needs a pro-active approach.

(2) New responses to the disappointing results of deinstitutionalization: ACT, AOT

As a result of the need to provide care in the community, the Assertive Community Treatment (ACT) and the Assisted Outpatient Treatment (AOT) programs were designed to actively reach out to mentally handicapped patients residing within the community. ACT was designed to be a "hospital without walls," delivering the same intensity of care as provided inpatients to those patients who reside in the community. In order to achieve its goals, ACT employs intensive rehabilitation and case management via a multidisciplinary team that is available 24-hours-a-day as well as for crisis management. The ACT team ensures that patients receive treatment by taking the aggressive approach of reaching out to the patient instead of waiting for the patient to take the initiative. Its availability, along with this assertive approach, allows more possibilities for medication compliance, psychiatric follow-ups and rehabilitation. This aggressive approach results in an increased number of patients who stay in the community and do not fall back into hospital or to jail. According to ACT, rehabilitation is teaching patients how to successfully manage their daily living (34, 35). Studies conducted in the U.S. in recent decades indicate that the ACT has proven to be effective in reducing the number of both hospitalization and inpatient bed days, providing adequate treatment for severely mentally ill patients, increased compliance with treatment and housing stability (36–39).

Another program that is gaining popularity in the U.S. is the Assisted Outpatient Treatment, AOT (29). The tragic death of Kendra Webdale, who was pushed in front of a New York City subway on January 1999 by a man with a history of mental illness, was the trigger for initiating this program (40). The AOT, also known in New York State as Kendra's Law, is a form of compulsory outpatient treatment. For a patient to be subject to Kendra's Law he must fulfill a number of statutory qualifications designed to insure that he is suffering from a mental disorder which might deteriorate and make him dangerous to himself or to others and that he is not likely to participate in voluntary treatment (41). The decision to employ an AOT Order is made by the Court. Failure

to comply with an AOT order results in civil commitment.

What distinguishes the AOT from other "conventional" compulsory outpatient treatment formulations (in Israel this would correspond to the approach adopted by section 11 of the TMPL) is both the assertive attitude taken by the AOT team and the fact that the State is obligated to allocate needed resources for overall treatment. These are key factors in successfully implementing the AOT. In his Final Report, the Governor of New York State presented data that have been collected on the implementation of the AOT (40). This report asserts that "people in the AOT have been able to improve their involvement in the service system as a result of their participation in the program, and by doing so they have improved their lives" (40). According to this report, there has been an almost 90% increase in the use of case management services among AOT recipients and substantial increases in utilizing both housing support and substance abuse services over a time period of almost five years since the law was acted. Almost all of these patients (97%) had been hospitalized three years prior to their participation in the AOT with an average of three hospitalizations per patient, and had also undergone homelessness, arrests and imprisonment.

The American experience offers clear directives in dealing with problems similar in their essence to the problems the Israeli mental health and legal systems might face. The key issue is to acknowledge that a change in the commitment model coupled with a shift to community-based psychiatry will change the balance between patients' rights and the ability of the State to use coercion in the direction of enhancing patients rights while monitoring them very closely within the community. Both ACT and the AOT provide patients with independence and freedom while maintaining supervision to ensure health and safety (34, 35).

(3) For the new U.S. responses to work, you need risk predictors

A closer look at this change in balance reveals that there are at least two other aspects of the problem that need to be addressed. The first deals with the ability to predict risk, and the second is concerned with the need to adequately train the legal and psychiatric systems in the field of forensic psychiatry. Both the shift to community-based psychiatry and acceptance of the legal model generate a need for an ability to accurately assess the risk for violence in mentally ill patients. Risk assessment predictions are necessary both in order to adopt a lucid decision to civilly commit a patient, and to discharge and monitor the patient within communities using an AOT-like program.

There are two main approaches to risk assessment of violence: clinical and actuarial. The clinical approach is based upon the clinical judgment of the examiner. There is no clear methodology governing the use of risk factors and therefore these might differ from case to case according to what seems relevant to the particular examiner. The actuarial approach is based upon explicit rules defining risk factors to be measured, the grading of those factors and how to mathematically combine the results, in order to establish an objective estimate of risk (29). Studies show that clinicians have had moderate ability to predict future risk using the clinical approach (29). A few years ago, an Israeli study was conducted to check the ability of clinicians to assess risk. The study examined the accuracy of psychiatric evaluations in predicting future danger before making a commitment decision over a seven-month period. The researchers processed 99 forms used to admit emergency room patients (42). These forms were filled out by the examining residents, who were asked to assess, on a 5-point scale (0, 25, 50, 75 or 100%), the chance that their patient would be violent toward others. They could also mark "unknown." This study indicates that the total accuracy of evaluation for residents staffing psychiatric emergency rooms stands at 61%. This figure means that only six out of ten patients were actually violent during their commitment period at the hospital. Other studies record similar rates. The best-known study of the ability of psychiatrists to predict patients' violent behavior was conducted in the mid-1990s by Lidz and his colleagues (43). Their results showed that only 53% of the patients were assessed by psychiatrists as likely to be violent, and in fact met that expectation when discharged into the community.

This moderate ability to assess risk according to the clinical approach is insufficient for ensuring that patients are not deprived of civil liberties. It is also

important, however, to avoid erroneously discharging a dangerous person, hence the interest in carefully monitoring patients predicted to be violent. The actuarial approach which has been developed recently might offer better solutions to these concerns. Although it has a lot of advantages, the actuarial approach has not been implemented until recently (29). Several actuarial instruments have now been developed, such as the Violence Risk Appraisal Guide (29, 33), the HCR-20 (29) and the Classification of Violent Risk (COVR®) (29, 44).

The most recent tool, COVR®, is based on data generated in the MacArthur Violence Risk Assessment Study (29) and is highly promising. As with previous tools, the purpose of this instrument is to estimate the risk that a patient who has been hospitalized for mental disorder poses to others. It accomplishes its purpose by use of interactive software that directs the evaluator through a chart review and a brief interview with the patient pre-constructed on the basis of a classification tree methodology. A person may score high risk or low risk, based on many different combinations of risk factors. The process begins with a first question asked of all persons being assessed. The following question is contingent on the answer to this first question, and so on, until each person is allocated by the classification tree into a final "risk class." The software then uses the collected answers to generate a report that provides a statistically valid estimate of the risk of violence of the evaluated patient during the first 20 weeks following discharge, on a risk scale from 1 to 76%. This systematic procedure enables the clinician to generate a number representing the degree of risk posed to others by the patient (29, 44).

The Challenge for Israel: to learn constructively from the U.S. experience

While the U.S. experience is very relevant to Israel in its attempt to update its Mental Health System, it is also clear that importing U.S. practice lock, stock and barrel would not be very effective. U.S. experience needs to be suitably built on to satisfy Israeli needs. The following three aspects seem to be most relevant to this process:

1. Adapt and validate an advanced tool for risk prediction;
2. Expand research, professional education and training in forensic psychiatry and related areas; and,
3. Change the attitude towards mentally ill patients and psychiatry.

(1) Adapt and validate an advanced tool for risk prediction

Improved risk prediction in Israel will require replicating the data base and analysis development undertaken in the U.S. It may be possible to economize on information if sufficient similarity with U.S. results can be established after suitable samples of the two populations have been compared. In any case, careful validation of a risk predictor tools is an indispensable first step.

After thorough validation, the implementation of an Israeli version of the COVR® and/or other advanced actuarial instruments by Israeli forensic psychiatrists will substantially contribute to a successful shift toward a community-based psychiatry and the adoption of the legal model. Furthermore, using such actuarial instruments holds the promise of increasing public confidence in psychiatrists' judgments. Such an actuarial base will also serve for more reliable forecasts of the budgetary implications of community psychiatry and thereby enhance support for this system on the part of the relevant government agencies and sick funds.

(2) Expand research, professional education and training in forensic psychiatry and related areas

Responding to the needs of the Israeli Mental Health System and fashioning a proper legal underpinning is not a one-time task, but a continuing one. As these needs change, so will the efficacy of the particular legal arrangements. The development of a proper response requires the proper intellectual infrastructure, dedicated to providing the country with the proposals it requires and deserves on the basis of the best empirical data and the most insightful analysis possible. In short, Israel requires an interdisciplinary Research Center for Law and Mental Health. The natural place for establishing such a center would be

at a university which has both a law school and a medical school. Establishing such an interdisciplinary center would ensure collaboration along with representation of every discipline.

A trained and professional Mental Health System is a system that has the ability to assess risk while maximizing patient rights. It is also cautious toward patients who might present future danger. The Israeli Mental Health System is both professional and well-trained. Nonetheless, the changes that have already begun demand that the system adjusts to a new and higher level of professionalism.

Like any other developed country, Israel would benefit from the establishment of a Forensic Psychiatry Fellowship Program for mental health issues within the framework of the proposed Research Center (the existing Forensic Psychiatry Program for Continuing Psychiatry Education at Tel Aviv University could serve as a base for the establishment of such a program). This would acknowledge the fact that this is a separate and distinguished discipline. Only psychiatrists who have taken the Fellowship Program would be certified to work as Forensic Psychiatrists or to appear as expert witnesses in Court. During their fellowship, these psychiatrists could also be specially trained to treat mentally ill patients who are engaged with the criminal justice system. They would also learn how to write expert opinions for the courts, conduct risk assessment evaluations, participate in research and acquire other skills needed for effective functioning.

The need for a professional mental health system does not stop at the door of the psychiatrist. The legal system also needs change, both in the concepts used by the law and in the training given to lawyers and judges. Past experience shows how a poor understanding of psychiatric concepts may lead both to bad laws and poor adjudication (45). One of the most important tasks of the proposed Research Center would be to facilitate communication and understanding between professionals from the disciplines of law and psychiatry. This will go far in helping to make the system in Israel more professional and just.

(3) Changing the attitudes towards mentally ill patients and psychiatry

Maybe the most important factor, along with the above changes and with the need to change the balance between patients' rights and the ability of the State to use coercion, is the need to gain the support of the major "players" in the mental health arena. Appelbaum points to this factor when he analyzes why the changes in commitment statutes during the 1960s and the 1970s did not deliver the promises they were meant to deliver: "To the extent that the new statutes ignored the feeling of those who were most directly involved in carrying them out, they were doomed never even to approach fulfillment of their goals" (28). Gaining the support of the main "players" for the innovations meant to address the challenges that the Israeli Mental Health System faces is the first step towards success. Along with this support, the Israeli public needs to acknowledge both the need for change and the promise of the solutions suggested. One of the most important conditions for gaining this support is by elevating the public confidence in the psychiatric profession. This can be done both by increasing the ability of psychiatrists to assess future risk of violence and by generating new knowledge through empirical and legal research in the mental health field.

Conclusion

The move towards community-based psychiatry and adaptation of the legal model will create a shift in the balance between patients' rights and the ability of the State to use coercion. These changes will require establishment of a Mental Health Law Research Center, and the adoption of risk assessment instruments which are more reliable and accurate than the clinical assessments used today. In addition, these changes require that the Mental Health System become more professional and better trained. The challenges for Israeli Mental Health Law are to incorporate these changes into law, and adjust to a new reality in which the vast majority of patients are entitled to reside in the community as long as they are closely monitored and treated. The challenge for the Israeli public is to increase its understanding of the nature of mental health and to support the evolutionary changes that make its management, in the social interest, more effective.

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Commentary

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"Mental health legislation can provide a legal framework for addressing critical issues such as the community integration of persons with mental disorders, the provision of care of high quality, the improvement of access to care, the protection of civil rights and the protection and promotion of rights in other critical areas such as housing, education and employment. Legislation can also play an important role in promoting mental health and preventing mental disorders. Mental health legislation is thus more than care and treatment legislation that is narrowly limited to the provision of treatment in institution-based health services" (1)

In this article, Toib tries to tie together various issues such as funding, medical insurance policy, community care, coercion, dangerousness, predictive instruments, professional education and research, etc. However, I cannot escape the conclusion that he actually deals with matters other than those declared. The level of interference by the judiciary has become a significant concern of medicine at large, as recently presented by Bloche (2), who noted that while the Courts considered issues such as abortion, assisted suicide, and rationing of care, they have also increasingly deferred to the medical profession's understanding of its purposes. Perhaps Toib's article demonstrates the gap between medical ethics and judiciary tactics. Furthermore, perhaps it reflects the huge distance between a rather detached judicial-academic approach and what actually happens in the field.

Toib chooses his references selectively, thus creating a certain impression regarding the state of affairs within the local mental health system, including forensic psychiatry in Israel. However, in spite of its shortcomings, the Israeli system is far from being on the verge of collapse. Proposals mentioned in Toib's article to shift the impetus on care from hospitalization to community-based facilities are actually being materialized. Facts and figures can be learned from official publications (3), although in a country as small and intimate as Israel, one can sometimes just look around. In contrast to other countries, mental patients are not filling Israeli prisons and there is not a significant number of mentally-ill wanderers and homeless. No consenting mental patient in need is denied treatment, and no one is deprived of emergency services. Major efforts are made, both finan-

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