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The Israeli Model of the "District Psychiatrist" A Fifty-Year Perspective

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Abstract: This article is about the role of the Israeli District Psychiatrist (DP), and explains how the DP came into being. The content is based upon documentation and the personal experience of the first author (M.K.) and reflects the views of both authors. The establishment of the DP model is deeply rooted in the history of mental health services in Israel. The authors illuminate philosophies and actual events leading to legislation of mental health laws, upon which the authority of the DP is based. The current laws broaden the scope of the District Psychiatrist's authority. In spite of a clear conflict of interest, the additional function of the DP as a director of the local psychiatric hospital governed by the Ministry of Health continued for 40 years, until the end of the 20th century. The new situation, backed by additional modern legislation, enables the DP to play a major role in the reforms that have characterized the mental health field in Israel over the past five years. Legislative attempts to reduce the authority of the District Psychiatrists have failed. In the emerging era of privatization and free enterprise, the position of the DP as a protector of patient rights for adequate treatment has become more prominent as has the conflict between the DP and service providers.

Preface

The Israeli model of the District Psychiatrist (DP) was officially born 50 years ago with the legislation of the "Law for Treatment of the Mentally Ill — 1955." The role of the DP is deeply interwoven with the development of mental health services in the country. The approach which led to the establishment of the DP's authority was derived from principles of charitable philosophy (e.g., "Parens Patriae" and "The Duty to Protect"), the practical experience of other nations, and local issues of public concern. Continuation of public concern, shifting of social views, "landmark" court rulings and advancements in technologies of treatment yielded the legislation of the 1991 version ("the new law") which is still in effect. The current law broadened the scope and depth of the District Psychiatrist's authority. In spite of a clear situation of conflict of interests, the double role of the DP as a director of the local psychiatric hospital governed by the Ministry of Health continued for 40 years, until the end of the 20th century. On June 1, 1995, this unfavorable situation was put to an end. The new situation, backed by additional modern legislation, has enabled the DP to play a major role in the huge reforms that have characterized the mental health field in Israel over the last five years. Attempts were initiated by several hospital managers to deny the District Psychiatrists their authority by trying to advance changes in legislation. So far, these attempts have been blocked by strong judicial and public opposition.

Historical Background

The foundations of the establishment of the DP role are deeply embedded in the history of mental health legislation in Israel. Processes of legislation in the country were conflictual and slow. The first judicial regulations of psychiatric treatment are referred to in the application of "The Ottoman law of asylums for the insane — 1892." The law reflects (with minor changes) the immense influence of the French law of 1838 (1) and was considered rather progressive at that time (2). The major Ottoman clauses included the obligation of government license for the operation of an asylum; inspection by the authorities; forbidding restrictive measures to be taken at home towards the mentally-ill, unless approved by two physicians (one of them a government employee) who personally checked the patient; guidelines for specific measures, aimed at protecting patients'

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rights and properties once involuntary hospitalization was indicated. These procedures involved the discretion of a religious authority and the head of the village (3). The philosophy of the Ottoman version focused upon centralization of bureauracy, consideration of religious authorities, and protecting patients' rights against malicious familial plots. However, implementation was scarcely materialized, and for decades, conditions of the mentally-ill were considered outrageously poor. Levy describes how the few dozen beds provided by the nuns of Saint Vincent de Paul in 1885, and later by the foundation of Ezrat Nashim Hospital in 1895, could not meet the demands. The British Mandate authorities, which took power after 1917, used to detain "dangerous mental patients" in special psychiatric wards located in jailhouses in Acre and Jerusalem, in intolerable conditions (4). The "non-dangerous" patients were in practice abandoned to wander in the streets. In fact, the authorities admitted in 1933 that there were insufficient beds to meet demands (5).

The major theme in the founding congress of the "Neuro-Psychiatric Society in the Land of Israel" in 1935 was a call of awareness for the devastating conditions of the mentally ill in the country: "In those days homeless mentally ill people wandered the streets of the cities, causing trouble and panic among the citizens. The British Mandate expressed indifference and the Jewish agencies merely requested the authorities to fulfill their civic duty towards the ill, and to protect the public. Arguments regarding 'who is responsible' continued until the founding of the State of Israel, with some concessions from each side but mainly with abandonment of the mentally ill to their fate" (6, pp. 128–129). In 1941, a committee was formed to supervise the hospitalization of Jewish mental patients. It was a modification of the Board of Control, based upon the British Mental Deficiency Act of 1913. The three members of the committee hired the services of Dr. Arthur Stern, a newcomer from Germany, as Inspector of Hospitalization Institutions (4). One can view Stern's role as a germinal model for the future District Psychiatrist. Still, the conditions were not much improved, since the main issue was lack of psychiatric beds. This situation was sharply criticized by young lawyer Haim Cohen (later to become a prominent judge in the Israeli Supreme Court) "…It was severely neglected by the legislature, an extreme neglect, full of dangers and irresponsibility…" (7, p. 149). In 1946 the fourth congress of the Neuro-Psychiatric Society appointed a "Forensic Psychiatry Committee," chaired by Dr. Heinz Herman, chairman of the society, whose duty it was to take care of "juvenile delinquency, criminals and prisoners."

The political, social and demographic changes that took place with the foundation of the State of Israel in 1948 required new initiatives in delivering psychiatric care. Consequently, the old Ottoman Law (which was still in effect until the mid-1950s) became clearly outdated, requiring new legislation. Besides, the first years of independence of the Jewish State witnessed massive waves of new immigrants, among them many refugees and Holocaust survivors in need of psychiatric care. The old public system could not compete with the mounting demands and an urgent need for additional containing institutions emerged. In the interim, private institutions of various shapes and sizes sprang up. They were inhabited by people in need of mental help, yet without sufficient inspection by the authorities of their quality of care. A huge gap in standards of treatment emerged between the high-quality publicly-owned hospitals, and the so-called private ("snake-pit") ones (8).

The Law of 1955 and the Establishment of the District Psychiatrist

In 1951, the public was shaken by the case of Geffen Sanitarium in which 12 inhabitants died within a year due to extreme neglect (8). The owner was tried and sent to prison. The exposure of the shocking details yielded a public outcry to initiate new legislation that would enable efficient control over psychiatric hospitalization and service providers. The director of the Ministry of Health appointed a three-member committee, Prof. H. Z. Winnik, Prof. P. Feldman and Prof. R. Meir, to study the various models practiced in other countries around the world, and to provide a draft for a new law that would reflect the most advanced approaches, based on the concept that the state is responsible for providing the basic health needs of the citizens. It should be noted that in those years psychiatric hospitalization was regarded as the best, and most compassionate, form of care. However, there have always been voices (mainly juridical

approaches) viewing hospitalization as a form of detention, as reflected by Justice Y. Bazak, that the legal arrangements for admitting and releasing patients from mental hospitals is a difficult issue, due to conflicting basic interests and the nature of mental disease. On the one hand, at times there is an urgent need for a patient to be hospitalized, in order to protect himself from self-harm, or to prevent danger towards others. On the other hand, the very nature of the disease prevents the patient from evaluating the severity of his condition. In these particular cases the patient resists hospitalization and regards his commitment as an act of persecution turned against him. It is essential to allow hospitalization even against his will. However, this urgent need collides openly with basic human rights. There is a greater danger that these rights will be needlessly violated due to professional error or even malicious intent (9).

Considering the floundering between two major views — the juridical and the medical — the committee came up with an entirely new approach, combining urgency with control. However, the newly emerged prototype favored a medically oriented approach, as explained by Prof. Winnik: "The treatment, including involuntary hospitalization, should be in the hands of specialized doctors, with the least interference by the judiciary or the police. The committee held the view that such interference 'stains' the case of the patient as a 'criminal' one, and in many cases needlessly delays and complicates treatment. Therefore, two major advancements were introduced — the District Psychiatrist and the District Psychiatric Committee. These changes are progressive and should not be changed…the committee was aware of the fact the proposition grants the District Psychiatrist a special authority, which was previously a judicial one…the District Psychiatrist is the reliable authority to ensure patient's rights, by his experience and knowledge of psychiatry" (10, p. 96). The proposal was strongly supported by Joseph Serlin, the Minister of Health, who stated that the guiding line of this proposal was the wish to avoid as much as possible any procedure that would alarm the patient or deter his relatives, and primarily be deprived of any resemblance of prison procedures (11).

The Knesset (Israeli Parliament) accepted the proposal on June 27, 1955, thus the statutory position of the DP was established, with emphasis on two major roles:

a. Government and public control over hospitalization of mental patients, especially the involuntary ones.
b. An independent professional consultation authority to the criminal court.

Winnik further suggested that in order to carry out his missions, the DP should be a senior physician furnished with adequate knowledge in psychiatry and law, and appointed by the government. (To this day, these suggestions are only partially fulfilled. The DP is appointed by the Minister of Health, but no formal juridical knowledge is required).

Levy pointed out that the 1955 law was considered an important legislative progression at the time, and gained international repute, since it offered a new model, favoring the medical view regarding involuntary hospitalization. A British committee came to study its applicability, prior to proposed changes in the British law of 1958 (12). Ginat and Bar-El draw attention to the main concern at that time, that there should be enough psychiatric beds to provide the basic right for adequate treatment. The issue of "the right to refuse treatment" was not considered at all (13).

The law of 1955 granted the DP authority in some 15 tasks, including: issuing hospitalization orders; appointing operators to carry out the order; authorizing the operation to enter any premises in order to carry out their mission; authorizing police assistance; choosing the admitting hospital; advising the criminal court; selecting a hospital for patients committed by court order; notifying the general guardian; decisions regarding transfer from one hospital to another in cases of disagreement between any of the parties involved; re-admittance of a runaway patient; discharge of a patient against the patient's or family's will, etc. A most important clause was derived from the experience learned in the Geffen affair: "A District Psychiatrist is authorized to enter any hospital and carry out any investigation or inspection he finds necessary to supervise efficient treatment and to implement the law, and the director and all the staff of the hospital should fully and sincerely answer his questions" (14).

With the inception of the new legislation an acute

problem of finding qualified professionals emerged. According to memories of several psychiatrists from the early days of the State of Israel, in the years prior to the implementation of the 1955 law, there existed an informal authority of a "psychiatrist authorized by the state," usually enacted as a secondary role by the director of the local district government psychiatric hospital (which carried out some of the abovementioned tasks). Therefore, with the implementation of the law, and facing a shortage of senior doctors to fulfill the role in the new establishment, authority was granted to those hospital directors — merely a continuity of a de facto existing situation. On the one hand, it was suggested that the seniority and the status of a hospital's medical director would naturally contribute to the authority of the DP. Another powerful factor was the practicality in utilization and availability of existing staff, within a reality of limited resources. On the other hand, this economic solution was not in the spirit of the law and diverted the original intent of the legislator, since the conflict of interests between the two roles was apparent. From a 50-year perspective, it seems that the compromise solution, which might have been unavoidable at the time (yet lasted for 40 years), apparently damaged the role and the status of the District Psychiatrist. The main shortcomings were related to issues of due process, and attention to human rights, at times severely criticized by the courts and the public. It seems that even today, 10 years after the separation between the two roles, the psychiatric system has to endure criticism derived from that unfavorable four-decade era.

At times there were District Psychiatrists with specific roles, such as the "National Deputy DP for Holding-Orders in Closed Institutions," a position held between the years 1974–1989, derived from the old version of clause 82 of the Criminal Code, designed to assist criminal courts by coordinating hospitalization court orders of drug addict offenders committed to psychiatric hospitalizations (as a mode of rehabilitation). The position became unnecessary when both the law and modes of treatment were changed and criminal drug addicts were no longer referred to standard psychiatric hospitals. Another specific position, still in existence, is that of the Military DP, authorized exclusively to commit military personnel in active duty.

The Law of 1991 and New Additional Roles for the District Psychiatrist

The cumulative criticism regarding the 1955 law finally yielded a new edition, with vast and major corrections (15). The spirit of the new law shifted remarkably towards impetus on issues of patients' rights and utilization of advancements in treatment technologies. New long-needed definitions were added, such as "psychiatrist" and "psychiatric examination" (which differs from "medical examination, physical and mental"), and consequently new definition of the DP. Many new tasks were added to the discretion of the DP, such as appointing an "examining psychiatrist"; issuing "compulsory examination order"; dividing both examination order and hospitalization order into two different categories — urgent and non-urgent; issuing "compulsory outpatient treatment order" (as well as coordinating court-ordered outpatient treatment in criminal cases). Commitments issued by the DP had become time-limited, with restricted renewal options. Indicators for initiating involuntary orders were more clearly defined, thus serving as guidelines for the DP in actualizing his authority. A major theme which clearly emerges from the spirit of the 1991 law is the crucial role of the DP, in both civil and criminal procedures, as being the keeper of adequate checks and balances between colliding forces, ensuring the patient's right to treatment as well as the utilization of least restrictive measures. The newly reformed approach also included additional elements of transparency and accountability of the DP's authority toward the judicial system.

The authorization of the DP to acquire pertinent information from any person, hospital or clinic was broadened, in order to assure his ability to fulfill the major duty of protecting patient's rights, as well as other various missions.

A failed attempt to end the duality of roles (being both a DP and a hospital director at the same time) could be traced in the history of the non-existent clause 2 of the 1991 law. The original clause was an obligatory condition that a DP could not hold a position of a hospital director at the same time. The clause was omitted from the draft in the last minute, thus it appears in the official version of the law as "Clause 2: omitted" (15).

The legislature further granted recognition of the DP authority, in the new 1995 additions to both the law for treatment and care of youth and the law for treatment of the mentally ill (16) (regarding the rights of juveniles in cases of indicated compulsory treatment). These included consulting the court in civil procedures where involuntary hospitalization of non-psychotic juveniles is clinically indicated. A special committee for juvenile patients was established, formed by five members.

References to the idea of broadening the role of the DP into a superintendent of the district mental health services could be traced in the Mencel–Doron agreement of 1978 (17). The general director of the Ministry of Health (Mencel) and the chairman of the dominant health services provider (Doron) had agreed upon dividing the country into 23 mental health regions in which services would be provided to anyone in need, regardless of his or her medical insurance affiliation. A proposal for a model of a superintendent of services (Regional Psychiatrist) was suggested, for missions of coordination the utilization of services (17). However, the agreement was only partially materialized.

Further elaboration, proposing a well-defined model, is found 12 years later, in a draft by "the national committee for the inspection functioning and efficiency of the health system," chaired by Supreme Court Judge Shoshana Netanyahu ("Netanyahu Committee," 1990). The committee suggested that the regional superintendent of mental health should be a DP with extended authority, including coordination of services, to prevent duplication and overlapping of services and to take care of professional issues, such as the advancement of underdeveloped services. The DP should also be in charge of quality control of all service providers and psychiatric facilities (18). The 1990 committee also noted that in 1955 the Knesset already expressed its aim that the District Psychiatrist should be an independent authority who does not carry any other clinical post in the system. "This recommendation was stressed repeatedly by two committees that examined the issue, in 1974 and 1981. However no steps were taken towards the recommended direction, probably due to lack of resources, although there is a clear conflict of interests between the vast authority granted to the District Psychiatrist and an executive active clinical role within a psychiatric hospital… the role of the District Psychiatrist is by nature a full-time position" (18).

The insurance reform of 1995; The Law of Rehabilitation for the Mentally Disabled in the Community — 2000; and the consolidation of the new model of the District Psychiatrist

The year 1995 brought a revolutionary step in the funding system of public medical services. The National Health Insurance Law implemented on January 1, 1995 imposed obligatory medical insurance on every citizen, funded by a progressive health tax. At the end of 1994 and just few days prior to the historical implementation, the Minister of Health, Dr. Efraim Sneh, announced that the inclusion of mental health services within the new medical insurance system will be postponed, "for no longer than six months" (19). On May 25, 1995, Attorney General Dorit Beinish (later to become Justice of the Supreme Court) issued a juridical opinion pointing at a sharp conflict of interests between the role of the District Psychiatrist and that of hospital director (20). The current situation in which a single person holds both positions had become unacceptable. Her opinion as well as pressures imposed by the medical insurance funds finally convinced the Ministry of Health to take the necessary, long-demanded action. Directors holding both positions were obliged to give up one of the roles, at their discretion. Two hospital directors preferred the role of a DP, while others preferred to remain hospital directors.

Ironically, due to various pressures and interests, the addition of mental health services into the new insurance system has not materialized (for more than a decade now). However, the establishment of independent DP offices granted momentum for the implementation of historical reforms and progressions which dramatically changed the landscape of mental health services in the country. For the first time there was a clear demarcation of regions between the six District Psychiatrists, in accordance with the partition of districts by the Ministry of Health. The staff of the District Psychiatrist ceased to be hospital personnel and became part of the government District Health Office. Impetus on service

delivery has gradually shifted towards community care. Private institutions within the region which did not meet adequate standards were closed, with patients referred either to facilities in the community or to public hospitals. In cases of disagreement or debate it was the District Psychiatrist who was required to impose his authority granted by clauses 31 and 32 of the 1991 law. The DP soon found himself as the major "gatekeeper" in his region. Long-neglected, yet much needed functions were revived. With additional staff, supervision, inspection and coordination of services became prominent tasks. Towards 1997, duties of regular inspection and licensure by the Ministry of Health, which has never been implemented before, has become a regular matter of fact. The new situation of the DP enabled him greater flexibility in choosing the adequate service to assist him in consulting the court. In fact, the new construction yielded major contributions to the advancement of forensic psychiatry in Israel, with the District Psychiatrist acting as a senior consulting authority to the court as well as a mentor to inexperienced colleagues in his district. It has become a common practice for the Supreme Court to appoint a committee of three District Psychiatrists to assist with their opinion in cases of high public interest whenever psychiatric issues were of crucial importance.

The consolidation of the DP Office as an independent department within the District Health Office, with various statutory roles, contributed to the process of facilitating the implementation of the important "Law for Rehabilitation of the Mentally Disabled in the Community" (2000), which went into effect in January 2001. This novel legislation, enabling mentally disabled persons to receive community-based rehabilitation services designed to improve their condition and to allow them to achieve an optimal level of social integration, contributed to the ongoing process of discharge of chronic hospitalized mental patients. Once the rehabilitation law went into effect, the district rehabilitation superintendent and coordinators were stationed in the District Psychiatrist office, operating under his auspices and authority. Utilization of authority granted by the DP enhanced the process of mobilizing (at times by compulsory discharge) long-term hospitalized patients into various facilities located in the community. Another new additional major role was inspection and assurance of quality of service delivered by community-based facilities run by private entrepreneurs.

In the middle of the first decade of the 21st century the District Psychiatrists found themselves in charge of a vast variety of functions as described by the Statistical Annual of Mental Health in Israel: "The District Mental Health Officers are charged with ensuring the availability and accessibility of the mental health services needed by the populations they serve and with promoting coordination between the different treatment settings in their areas. District office staff members participate in setting national mental health policy for ambulatory care, rehabilitation and hospital services. The directors of the District Offices also function as District Psychiatrists. In this role, they are authorized to issue orders for compulsory examination, ambulatory treatment and hospitalization, as well as to carry out examinations at the request of the court and to administer the District Psychiatric Committees. They head multidisciplinary staffs and have the responsibility for developing services and monitoring quality of care at the local level. They also have a role in promoting high professional standards of mental health and substance abuse care in other public systems (e.g., general health services, welfare services, and the educational system). The District Psychiatrists also provide the liaison between the National Office and the health care providers and managers in the treatment and rehabilitation setting at the local level" (21, p. 133).

There have been several reservations, regarding the new statutory position of the DP, arguing that with the new roles perhaps a new conflict of interests might emerge: Aviram claims that holding of both positions (DP and "Regional Psychiatrist") by a single authority (the "District Mental Health Officer") yields a potential conflict of interests, since theoretically the DP should be under the control of the Regional Psychiatrist (22). However, reality demonstrated that it was mainly the authority granted by the 1991 law that enabled the DP to function in favor of service consumers, at times during a conflictual atmosphere created by clashing interests of local service providers. Thus it was argued that the law which constitutes the very backbone of the DP

authority should be retained. The authority granted to issue involuntary orders was first criticized by Levy, claiming that though enacted as a mode of treatment, involuntary hospitalization is primarily an act of deprivation of freedom. Thus authority should be at the discretion of the Judiciary and not the DP (23). Eleven years later, in 2000, the debate was revived, with declared arguments such as a wish to abolish stigmatization and to abandon "paternalistic roles" (24). It seems that perhaps part of the motivation was the result of organizational logic, aimed at restoring the power and influence of hospital directors by dismantling the DP of his authority, which will be granted partially to the court and partially to hospital directors. This approach was strongly negated (25, 26). The main arguments against the new initiative were that at a pertinent period a patients' freedom is primarily deprived by the disease itself; that compulsory management ("paternalism") is at times essential; and that stigmatization is multifactorial and deeply rooted. However, careful examination of the various arguments yielded a reasonable proposal, in which the main theme focused upon shortening the span of compulsory management authorized by the DP to a necessary minimal demanded period (48–72 hours) and consequently granting authority to a statutory committee or the court. This approach which limits DP authority to essential critical stages of psychiatric emergency was strongly supported by the DPs. In fact the proposal could reflect a consensus regarding new legislation initiatives.

The Forum of District Psychiatrists

The forum, founded in 1985, was aimed at self-instructive meetings and mutual exchange of practical experience as well as the study of pertinent court rulings and judicial landmarks. In fact, it was the first body to study the application of forensic psychiatry in Israel. Members of the forum took part in professional discussions preceding important legislation initiatives (the radical changing of clause 82 of the criminal code in 1988, changes in the mental health law in 1991, additions to youth law in 1995). In the last years the Supreme Court has appointed panels of District Psychiatrists to assist by issuing opinions in specific appeals.

In view of the reforms of 1995 that yielded the new structure and functions of the DP office, the aims of the forum were reviewed in 1997. The decision was that "the nature of the meetings will refer to the current character of the duties of the DP, including various aspects of inspection and control in the field of mental health as well as judicial issues" (27).

Conclusion

The DP is a unique Israeli model, a merger of psychiatric and legal authority (28), with specific roles in the field of mental health regarding both disciples. It took nearly half a century to reach the original aims of the legislator and to establish independent professional units under the management of the DP. This favorable development made it possible for the DP to actualize substantial parts in the scale of his missions.

The law of 1955 established the authority of the DP. However, it could not fulfill the "vision" of the legislator, due to built-in structural defects. The duality of roles (being both a DP and a director of a psychiatric institution, permitted by the law) resulted in unfavorable conflict of interests. The ambiguity of crucial clauses and the lack of time were limiting procedures attributed to the mounting criticism which damaged the role of the DP and perhaps even the public image of the psychiatric profession within Israeli society.

Major efforts to correct the shortcomings of the 1955 legislation are prominently visible in the new 1991 edition. Significant clauses were added or changed, reflecting both patients' rights and clarification of conditions for compulsory treatment, imposing additional duties upon the DP. However, the issue of dual roles was still unresolved, for another four years.

The events of 1995 which initiated the independent status of the DP enabled him to take a major role in reforms heading towards the decline of the classical mental hospital and shifting impetus towards community care. There has been some concern regarding the vast authority granted to the DP. However, it appears that his authority is primarily enacted in the service of mental health consumers.

Once the issue of dual roles was resolved, tension between the two positions grew, leading to abortive

legislation initiatives. The emergence of a novel establishment of the DP as an independent, community-based institution and a "gatekeeper" with a "least restrictive measures" attitude dimmed criticism considerably. The DP authority gained support from both the judiciary and by voluntary organizations (e.g., Ozma — The Israel Forum of Families of People with Mental Illness). To this day the DP is appreciated and trusted by the judiciary system (29).

In the emerging era of privatization and free enterprise, the position of the DP as protector of patients' right for adequate treatment became more prominent and conflict of interest between him and service providers more obvious.

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