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**Mental Health Policy in Israel**

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**Israel's Community Based Mental Health Services**

**Abstract**:

In this chapter we will review Israel’s mental health system policy development and highlight its unique part of community based mental health services. Many of the policies implemented in Israel are very much based on the western model of psychiatry with some adjustment to the unique needs of the diverse Israeli society and the developments regarding to the human rights of persons with disabilities. The overview will also discuss the future of community-based mental health services and the need to promote a community reform in order to fulfill the mental health recovery concepts.

Chapter outline:

1. Introduction
2. Israel Mental Health System Development in the Israeli context
3. Community based mental health services
4. A future of Community reform
5. Final remarks
6. References

**Israel Mental Health System Development in the Israeli Context**

Israel is a relatively young, multicultural state, with considerable national, religious and ethnic diversity. Since its establishment in 1948, Israel has been in a constant state of emergency, including a long-standing conflict with the Palestinian population. It has also had to contend with the complex issue of nationality among its Palestinian Arab citizens. The state, established in the wake of the immensely collective trauma of the Holocaust, immediately faced the challenging of taking in in millions of Jewish refugees from all over the world, mainly from Europe and the neighboring Arab States, in a very short period of time.

The current population of Israel amounts to some 9,291,000, of which 6.870 million are Jews (73.9% of the overall population), 1.956 million Arabs (21.1%), and 465,000 other ethnicities (5.0%) (The Central Bureau of Statistics, 2020). This cultural diversity is attributable to, among other things, to waves of immigration over the years; some 25% of today’s population was not born in Israel, arriving in one of the various waves of immigration. The last waves of immigration arrived in the 1990s with a mass influx from Russia and Ethiopia. Added to this complexity is, of course, Israel’s precarious security situation, both external and internal, as mentioned above.

It is in this complex and challenging environment that Israel’s mental health system, reflecting both Western psychiatry and more traditional systems (Levav & Grinshpoon, 2004) must operate. The health system is based on the National Health Insurance Law, 1994, according to which all residents are entitled to medical insurance coverage via the Health Tax according to their level of income. Most of the population receives treatment via one of the four Health Maintenance Organizations (HMOs) that were established by trade unions even prior to the state itself, (Aviram, 2019; Levav & Grinshpoon, 2004).

There is a lack of precise data in Israel as to the number of people diagnosed with Serious Mental Illness (SMI), or people contending with a mental disability, an issue common to many other countries. The health system estimates that about 130,000–150,000 people in Israel are estimated to be living with SMI.. If we add to this the family members taking care of them, we then arrive at a number closer to 400,000 people who are affected by mental health problems, out of a total population of 9 million people. In fact, the population of people with mental disorders in Israel represents the large proportion of people with disabilities, amounting to 41% of those receiving disability pensions (about 115,000 men and women) (Aviram, 2019; David, 2020; Aviram & Azari-Viesel, 2015; The National Insurance Institute 2014, the National Council on Rehabilitation, 2021). While the issue of mental health problem clearly affects a large portion of the population, the accepted view of people with mental disabilities is rife with structural, public and personal stigma toward those affected.

In terms of data on psychiatric hospitalization, in 2019 there were 58,641 visits to the psychiatric emergency rooms (ER) at both the general and psychiatric hospitals, 63% of which were at government hospitals. Forty percent of those visits ended in hospital admissions, 1/3 of those under the age of 25 were hospitalized compared with 44% of those 25 years or above. There are 3,642 beds in Israel's psychiatric hospitals. Of these, 3,475 are beds in public hospitals (Ministry of Health, 2020).

As is the case with other countries too, mental health is a sphere that has long been sorely neglected in Israel, both in terms of the response and services provided for the unique needs of those with mental disabilities and mental illness, and also in terms of the professional aspect of developing innovative professional practices (WHO, 2021; Aviram, 2019; David, 2020).

As noted in the opening of this chapter, the State of Israel evolved as a multiethnic immigrant state In the early days of the state, government authorities had to focus their efforts on developing and establishing the very institutions of the state, including system to help accommodate millions of immigrants arriving in the aftermath of the Holocaust. Even in the early days of the state, a mental health system had to be developed to provide a relevant response to those affected by the traumatic events of that period, including the numerous cases of Holocaust survivors, immigrants and even the state’s founders, who required psychiatric treatment (Aviram, 2019; Aviram & Shnit, 1981). At that time, there was an urgent need to provide a psychiatric response for many suffering from mental illness, and emphasis was placed on separating them from the general population and placing them in psychiatric institutions. This usually W involved involuntary commitment, and the quality of treatment was vastly inferior to the treatment of physical illnesses (Mark & Siegal, 2009).

While mental health policy in the early days of the state may be considered somewhat minimal, or even primitive, social welfare legislation in Israel was much more significant. Even from its inception, the State of Israel enacted broad social legislation (Gal & Benish, 2018; Hovav, Lawental and Katan, 2012). Thus. both the health and mental health systems developed as discrete organizational and professional systems, separate from the social welfare and education structures. To this day, the health and mental health services are operated via the central government and the HMOs, rather than via local government, as is the case with other welfare systems.

The mental health system in the early days of the state was based mainly on the mental health services that developed during the British Mandate that ruled in Israel between 1917–1948. As such, it existed in hospitals, non-profit organizations and private profit organizations, alongside institutions of the pre-state HMOs that provided medical treatment within the community. At the time belonging to one of these was based on affiliation to one of the trade unions, and these HMOs gave marginal attention to mental health at best. The national, and later, state mental health system provided a response to those who did not belong to the HMOs, and consequently it began to allocate budgets for the various psychiatric institutions (both the public and private ones) which were already operating at the time (Aviram, 2019). The health system was based on the independence and power of its physicians, the Government Hospital Directors’ Forum, who had a monopoly in the field of mental health. Their power and bias in favor of hospitalization often delayed and even prevented the implementation of changes towards more community-based solutions (Aviram, 1991, 2019; Ginat, 1992).

Mental health legislation, especially the enactment of the Treatment of the Mentally Ill Law, 5715-1955 (which has since been amended on several occasions).in the early years of the state reflected the hospitalization approach and The budgetary sources originating from contributions of philanthropists and various funds were mainly used in support of hospital beds and inpatient days. (Aviram, 2019). Until the mid-1960s, emphasis was placed on increasing the number of hospital beds and providing a response to those in need of hospitalization. During the sixties, attention began to be paid to the serious problems of mental health hospitalization. Already at that early stage, calls were heard for a change in the existing setup and for reorganization of the mental health services in order to reduce long-term hospitalization, along with initial discussions on prevention and rehabilitation instead (Aviram, 1991). In the early 1970s, there were more than 8,000 hospital beds for psychiatric patients in all the hospitalization institutions in Israel. 2.7 beds for every 1,000 residents (compared with 1.3 in 1948 and 0.4 in 2016) (Aviram, 2019, 1991).

The lack of hospital beds, together with social and professional developments, led to a change in the early seventies, at first mainly in terms of the dialogue on the required changes. This appeal emanated both from a bottom-up approach by social organizations calling for changes in the field, along with expansion of the social approach advocating integration within the community, together with forces from within the government. One example is that of the State Comptroller’s Office, which in the early 1970s examined the psychiatric and mental health system and commented on the lack of community-based solutions to provide support (State Comptroller, 1970). The first attempt to effect a change in mental health policy and reform arrived in the form of the Ministry of Health’s 1972 reorganization program. The program was based on understanding the new trends, mainly in the United State, which advocated transferring the focal point of the mental health system from the psychiatric hospitals to community mental health services, mainly by downsizing the number of hospital beds, reducing the number of inpatients and the length of hospital stay, in parallel to development of the community mental health services available to the population (Ministry of Health, 1972; Aviram, 2019). The program proposed enhancing community mental health service centers (based on the model of the Kennedy administration in the United States, whose objectives were providing therapeutic services in the vicinity of the patient's home and providing preventive services to counter the development of individual, family and social pathology (Aviram, 2019; Tramer, 1975, 1981). The program placed emphasis on the fundamental concepts of the community approach to mental health: regionality (accessibility), comprehensiveness, and continuity of care (the constancy and variety of the services). The original program proposed establishing a regional community center in each geographical area in Israel to serve the community and provide hospitalization and emergency services, out-patient clinics, partial hospitalization, along with counseling, and education services. This was based on the understanding that coordinated work with the various health and welfare agencies would be a prerequisite for implementation of such a program, along with adapting them to the health and mental health services framework. The main argument in favor of the deinstitutionalization program was a resulting, significant decline in the number of inpatients that would reduce hospitalization costs and enable the closure of lesser quality private hospitals. (Aviram, 2019).