Editorial: Commentary on Israel's Psychiatric Rehabilitation Law

Robert E. Drake, Michael F. Hogan, Mike Slade and Graham Thornicroft

The first 10 years of Israel's Psychiatric Rehabilitation Law represent the successful first stage in system change – an array of community rehabilitation services has been created. Although it has increased client-centeredness, moved some rehabilitation services into the community, and increased social inclusion, a number of next steps might be considered.

In October of 2010 the Israeli national health/mental health leadership met in a special workshop sponsored by the Israel National Institute for Health Policy Research to review the 2000 Psychiatric Rehabilitation Law. Four international consultants who participated in the workshop offered the following suggestions for potential next steps in Israel.

INDIVIDUAL RECOVERY GOALS

The concepts of client-centeredness and recovery have evolved over several decades with increasing focus on helping people to define and develop a life they consider meaningful, elucidating the process of and techniques for honoring and supporting their individualized journeys, and challenging traditional mental health attitudes and procedures (1). People with lived experience have emphasized the centrality of hope, identity, meaning, and personal responsibility (2-5). In Israel the involvement of service users has given voice to many individuals, but the next stage may require developing egalitarian partnerships that go beyond traditional clinical relationships (6). True partnerships require sharing power in all aspects of defining goals and making decisions.

Israel's Psychiatric Rehabilitation Law enshrines the treatment and support rights of individuals. The next policy evolution may make more explicit that these services and supports should be offered in the service of the individual's life goals, rather than being given in their best interests – a subtle distinction with profound implications (7).

These ideas will affect the process and content of mental health care also. The danger here is viewing services as an end in themselves, so that "compliance" and "adherence" are seen as desirable. A pro-recovery approach to clinical care, by contrast, emphasizes coherence, values, alliance, choice and empowerment (8).

COMMUNITY INTEGRATION AND DISCRIMINATION

People need to be in the community to pursue their journeys, to reach their functional goals, to be included in society, and to live independently. Rehabilitation services must therefore be delivered in the community (9).

True community integration and social inclusion depend upon having opportunities available in the mainstream society outside of the mental health system. Overcoming discrimination is therefore as important as providing clinical services (10). The most powerful antidote for discrimination is close social contact – people drop their false prejudices when they know or work with someone who has a mental illness (11). Recent research demonstrates that anti-discrimination programs can be effective, through the direct involvement of consumers as teachers interacting with the public (12). Thus Israel might consider adding an anti-discrimination campaign to enhance its efforts to move rehabilitation services into the community.

EVIDENCE-BASED INTERVENTIONS

Interventions that are demonstrably effective are termed evidence-based practices. By definition, they are clearly defined (in a manual, book, video and other guidelines), replicable (usually based on training and a fidelity measure), and supported by rigorous research (typically more than one randomized controlled trial) (13). Evidence-based psychiatric rehabilitation interventions help people with mental illnesses to achieve functional goals that they define as personally meaningful, such as independent living, competitive employment, mainstream education, friendships outside of the mental health system, and managing their own illnesses (14). Dependence on the mental health system is of course not anyone's rehabilitation goal.

Several evidence-based rehabilitation practices promote recovery goals. Supported housing and assertive community treatment help people to avoid hospitalizations and homelessness and to succeed in independent

community living settings (15, 16). Supported employment and education help them to attain mainstream jobs and educational experiences in the community (17). Illness management interventions help them to manage their illnesses in the community using natural supports (18). Family interventions help them to improve relationships with their families (19).

Evidence-based psychiatric rehabilitation interventions embody several common features. Multidisciplinary teams deliver the interventions, always focusing on the client's goals, using a process of shared decision-making, aiming at inclusion in the mainstream community, embracing natural supports, and helping people to acquire the skills they need to succeed in environments of their choice.

MEASUREMENT

Using evidence-based practices requires a complementary insistence on measurement and outcomes research. Rehabilitation addresses functional outcomes that are observable and measurable. Documenting the proportion of people who are living independently, attending school, working in competitive jobs, avoiding social isolation, and managing their own symptoms is relatively straightforward. Standardized measures exist for each of these areas (20), and the field is rapidly developing benchmarks (21). Without outcome measurement and benchmarks, program leaders do not know whether clients are recovering, and providers naturally drift toward offering traditional services within clinics – not optimal for pursuing recovery. Outcomes show clearly whether or not clients are meeting their goals.

Measuring process, usually in the form of fidelity to evidence-based practices, is as important as measuring outcomes (22). Outcomes are often skewed by selection bias because programs tend to provide services for clients who are easier to treat and more likely to achieve good outcomes, thereby neglecting the most needy clients (23). Process measures ensure that high-quality services are in place.

Community-based research also enhances quality. Evidence-based practices must be tested and adapted to local cultural and economic contexts, and Israel would be well served by expanding its current research on community-based care and outcomes (e.g., 24).

SYSTEM CHANGE

Implementing evidence-based practices on a large scale and ensuring sustainability require widespread dissemination, training, adoption, monitoring and feedback (25, 26). Research on implementation, despite a paucity of controlled trials, clearly establishes that training alone is insufficient to put in place and sustain an evidence-based practice. Instead, an effective approach should involve stakeholders at many different levels: e.g., regional mental health authorities attending to financial incentives and accountability, technical assistance centers providing training and fidelity assessments, clinic directors overseeing workforce requirements and medical records, team leaders using field-based supervision and data to reinforce clinicians, and clinicians learning new skills and helping each other. Strong leaders prioritize the new practice, actively overcome whatever barriers are encountered, redesign the flow of work to support the new practice, and reinforce change through measurement and feedback.

Currently the most widely used mechanism for implementation of evidence-based practices is the regional technical assistance center (27). In this strategy experts provide consultation to administrators, training and longitudinal supervision to clinicians, and monitoring and feedback to programs via fidelity visits. A more recent approach, the learning collaborative model (28), involves multidisciplinary teams from several practice sites meeting with researchers to discuss their processes of care and desired improvements. After agreeing on goals and strategies for change, they help each other and monitor key outcomes. In the future, implementation is likely to rely more on information technology (29). Several approaches are developing and being tested rapidly: distance learning, telemedicine, mobile technology, self-treatment programs and electronic decision support systems (30). Each shows great promise thus far.

CONCLUSIONS

Israel's Psychiatric Rehabilitation Law has inspired hope by establishing a right to rehabilitation services and a record of early implementation success. Suggested next steps include fully incorporating recovery values, emphasizing community integration and social inclusion, adopting evidence-based practices, measuring process and outcomes, and planning widespread dissemination and implementation.

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Contact information for Authors:

Robert E. Drake
Dartmouth Psychiatric Research Center, Lebanon, NH, USA
Robert.E.Drake@Dartmouth.edu

Michael F. Hogan
Office of Mental Health, Albany, NY, USA

Mike Slade
Health Service and Population Research Department, Institute of Psychiatry, King's College London, London, UK

Graham Thornicroft
Health Service and Population Research Department, Institute of Psychiatry, King's College London, London, UK