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Recovery in Israel: A legislative recovery response to the needs–rights paradox

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Abstract

This paper uses the framework of the applied social science needs/rights antinomy to describe the efforts of Israel's mental health system in transforming a hospital-based orientation to services for individuals with a severe mental illness, to a community-based recovery orientation. On the one hand, a rationale for the provision of services to individuals with a severe mental illness that stresses these individuals' needs can justify the allocation of society's limited resources by referring to an objectively determinable set of psychiatric needs. However, this rationale may establish an inherent asymmetry between the adequate help provider and deficient help user. On the other hand, a rationale for providing psychiatric rehabilitation services that stresses the fundamental symmetry between the help provider and the help user is empowering, thus consistent with the recovery approach. However, this rationale does not provide a mechanism for negotiating the vague boundary between mental health and mental illness. Israel's mental health system has operationalized a policy that emphasizes rights as well as needs by legislating for a comprehensive set of rehabilitation services that individuals meeting the eligibility criteria may receive. This paper discusses this approach's achievements, challenges and implications for future policy, research, and practice.

Psychiatric rehabilitation and the needs–rights paradox and antinomies

Approximately a decade ago, Israel's parliament enacted the Rehabilitation in the Community of Persons with Mental Disabilities law (in this paper, this law will be referred to as 'the law'). A principal goal of this law was to incorporate within Israel's existing mental health system a set of legislated procedures together with an administrative body to oversee the implementation of the procedures according to which individuals with psychiatric disabilities would receive the services that should help them achieve autonomy and community integration. This paper uses the framework of the applied social science needs–rights antinomy (Rappaport, 1981, 1986) to describe the above efforts of Israel's mental health system to transform a hospital-based orientation to a recovery orientated one. In this paper, the term antinomy refers to these inconsistent elements or propositions whose persistent interrelationships make up paradoxes.

Rappaport (1981, p. 2) contends that 'human social systems for the living are paradoxical in nature' and that 'basic to the idea of paradox is the notion

of antinomy.' Rappaport's article 'In praise of paradox: A social policy of empowerment over prevention' was first published in the *Journal of Community Psychology*. It was then reprinted in a book of essays devoted to the argument that social problems often need to be redefined as an important step toward their solution (Rappaport, 1986). In this essay, Rappaport quotes the *Oxford English Dictionary*, (1971) definition of paradox as 'a statement or proposition which on the face of it seems self-contradictory, absurd, or at variance with common sense, though on investigation or when explained, it may prove to be well-founded ... often applied to a proposition or a statement that is actually self-contradictory ... essentially absurd and false' (Rappaport, 1981, p. 2). A more recent, terser, and more complex definition of paradox is that it refers to 'contradictory yet inter-related elements that exist simultaneously and persist over time' (Smith & Lewis, 2011, p. 381). As mentioned above, the term antinomy refers to these inconsistent elements or propositions whose persistent interrelationships make up the paradoxes that persistently challenge the efforts of social systems to ameliorate such serious social and personal problems

as mental illness because these components and prepositions are ‘intimately intertwined’ (Rappaport, 1981, p. 3).

Rappaport (1981) contends that at its most prominent period, from 1960 to 1980, the community mental health movement was based on a needs approach to dealing with personal and social problems. In his brief narrative of the history of the community mental health movement, he claims that when this movement began to lose its intellectual vigour and social power, it was challenged by the rights approach to human problems. Thus, Rappaport (1986) predicted that for the remaining years of the last century, the community mental health movement would be faced by a paradox composed of two antinomic views of how to help the poor, people with physical, psychiatric, developmental and intellectual disabilities, juveniles, and the elderly. According to the view that attributes suffering to the deprivation of basic needs, these individuals are ‘to be helped, socialized, trained, given skills, and have their illnesses prevented’ (Rappaport, 1986, p. 151). However, according to the view that attributes suffering to the violation of individuals’ rights as citizens, these individuals are to be ensured of rights and choices.

On the one hand, a rationale for the provision of services to individuals with a psychiatric disability that stresses these individuals’ needs justifies the allocation of society’s limited resources by referring to an objective determinable set of needs associated with psychiatric disability. Thus, it facilitates the identification of a population of individuals who due to their psychiatric disability often have a serious disadvantage which generates significant difficulties in the core domains of living such as the physical, emotional, familial, social, vocational and economic areas. Once these individuals are identified, they can be afforded the services that may reduce the symptoms associated with the illness and ameliorate the variety of deficiencies produced by these symptoms across the various life domains.

On the other hand, a rationale based strictly on the basis of need may establish an inherent asymmetry between the adequate service provider and deficient consumer, thus, increasing the latter’s dependency and even further decreasing that person’s power. Alternatively, a rationale for providing psychiatric rehabilitation services that stresses the rights of individuals with a severe mental illness to receive services, designed to help them achieve autonomy and community integration should establish a fundamental symmetry between the service provider and the service user. This rationale should be inherently empowering and, thus, consistent with the recovery approach to severe mental illness (Slade et al., this issue, pp. 1–4). Along these lines, over the

past 20 years the recovery movement has set the goal of empowering help users by increasing their activity and participation in mental health services in order to elevate them to the level of modern recovery orientated services (Tse & Kan, this issue, pp. 40–47). However, this rationale does not provide a mechanism for negotiating the vague boundary between the inherent freedom and responsibility regarding one’s circumstances that a rights approach to social service provision both attributes to the person with a mental illness and considers to be one of the significant goals of the service provided and the constraints placed on the exercise of this freedom and responsibility by the mental illness. Thus, it does not provide a professional and scientific rationale for allocating Israel’s limited resources to individuals with a severe mental illness. As a way of resolving the needs–rights paradox, Rappaport (1981, pp. 15–21), advocates empowerment as both a symbolic plan of action and as a set of ends and means by which the capacity for individuals to control their own lives is enhanced. Empowerment is also one of the central principles of the recovery movement. Advocates of this movement include the right to make one’s own health decisions in their denotative definition of empowerment (Frese et al., 2009; Tomes, 2006).

This paper describes Israel’s Rehabilitation in the Community of Persons with Mental Disabilities law, in part, as an effort to operationalize a recovery orientated mental health policy that emphasizes rights as well as needs. The formulation of the law describes its purpose as a means ‘to strive for and advance the rehabilitation and integration of the mentally disabled in the community in order to allow them to achieve the maximum degree of functional independence and the highest quality in life while preserving their dignity in the spirit of the Basic Law: Human Dignity and Liberty, 1992, S. H. 1391.

According to Smith and Lewis (2011), when paradoxical tensions become salient they can elicit negative responses and positive responses. The negative responses consist of an emphasis on consistency, emotional anxiety, defensiveness, and organizational inertia. Accepting and/or confronting the paradoxes that generate the negative responses can initiate a positive virtuous cycle. As a consequence of the latter cycle, these tensions can come to be viewed as ‘an invitation for creativity and opportunity’ (Smith & Lewis, 2011, p. 391).

Smith and Lewis present a dynamic equilibrium model of organizing that consists of a strategy for resolving societal and organizational paradoxical tensions. This strategy requires an organization to become aware of the essential paradoxes that confront it. Then, it can attempt to resolve these paradoxes by alternating between splitting and integrating

their antinomic components. For example, in the case of the community mental health paradox, scientific and professional understanding of the conditions that induce dependency and those that promote empowerment could be used to establish rules for appropriately alternating between these two sets of conditions. When these paradoxes cannot be resolved in this manner, such means as establishing a format for initiating a dialogue between service providers and patients can be introduced to accept and work through those tensions that are consequence of the unresolved paradoxes.

This paper also compares this law's achievements to the state of affairs before its enactment. It does not claim that the law was explicitly motivated by a paradox approach to complex societal tensions. However, because the law appears to be especially sensitive to the extent to which and the manner in which severe mental illness generates such tensions, it uses this approach to discuss the challenges and implications of this law's accomplishments and limitations for future policy development, research, and practice.

Psychiatric services in Israel before the enactment of the law

Until recently, services for people with severe mental illness in Israel included primarily psychotropic medication and limited psychotherapy dispensed by psychiatric hospitals and community mental health centres. Additional services were available in the form of disability benefits, vocational rehabilitation provided by the National Insurance Institute, and hostels and social clubs sponsored by ENOSH, an organization of families of individuals who are receiving services for their psychiatric disabilities. These services, however, were limited both with regard to the number of individuals to whom they were provided and in the extent to which they met those individuals' needs.

Historically, there were three public agencies mainly responsible for delivering rehabilitation services for individuals with a variety of disabilities: The National Insurance Institute, the Ministry of Welfare and Labor (for many years it has not included labour – today it is called the Ministry of Social Affairs and Social Services), and the Ministry of Health. In reality, however, the needs of individuals with psychiatric disabilities who could be helped by rehabilitation services were met in a very partial manner. The Ministry of Welfare and Labor provided special services to individuals with cognitive disabilities, sensory disabilities such as visual and hearing impairment, and for individuals with geriatric illnesses and disabilities, but not for

individuals with severe mental illness. Furthermore, whereas clinics managed by Israel's major health-care insurance plans covered a broad range of services for people with physical illnesses and disabilities, services for people with severe mental illness as well as geriatric illnesses and disabilities were offered by special healthcare clinics managed by the Ministry of Health.

The Rehabilitation of Persons with a Psychiatric Disability in the Community law

In the year 2000 a group of citizens, mental health professionals working in public and government agencies, patients, family members, activists and academics, became concerned that the needs of individuals with psychiatric disabilities were not being met by the existing rehabilitation services being provided. An important source of this concern was the feeling that negative attitudes and stereotypes associated with mental illness contributed significantly to the failure of the responsible public agencies to help individuals with severe mental illness gratify their basic needs, fulfil their values, and achieve community integration. This concern motivated both the establishment of the Israeli Organization for Psychosocial Services and the formation of a special interest group that began to put pressure on the Ministry of Health for the formulation of special legislation for the rehabilitation of individuals with a psychiatric disability in the community. These various groups of stakeholders were also inspired by the vision of recovery that had become a source for optimistic guidelines for the rehabilitation of individuals with psychiatric disabilities around the world (Adams, this issue, pp. 70–78; Anthony, 1993; Oades & Anderson, this issue, pp. 5–10; Perkins & Slade, this issue, pp. 29–39; Piat & Sabetti, this issue, pp. 19–28; Slade et al., this issue, pp. 1–4). Central to this vision is the belief that people with a severe mental illness should be encouraged to view rehabilitation services not only as a response to the many needs caused by the mental illness but also as means by which they can actualize their right to engage in activities associated with a socially and personally meaningful life. Thus, the goal of the law for the Rehabilitation in the Community of Persons with a Psychiatric Disability is to ascertain the integration of individuals with severe mental illness in the community and enable them to achieve the maximum degree of functional autonomy and quality of life, while preserving their human dignity and freedom in keeping with the spirit of the Basic Law: Human Dignity and Liberty, passed by the Knesset in 1992.

To achieve this goal, the legislation specified a set (referred to in the law as a 'basket of rehabilitation

services’) of psychiatric rehabilitation services to be provided to patients who meet eligibility requirements, and the mechanisms for supervising the implementation of the legislation. In the following, we briefly describe three such mechanisms that appear to provide the means of carrying out the law in a manner which attempts to articulate and to integrate effectively the needs and rights aspects of recovery orientated rehabilitation services: 1) The ‘basket’ of psychiatric rehabilitation services, 2) The regional rehabilitation committee, and 3) the Council for the Rehabilitation of Persons with a Psychiatric Disability in the Community.

Recovery orientated psychiatric rehabilitation mechanisms: Confronting the needs–rights paradox

The ‘basket of rehabilitation services’. The ‘basket of rehabilitation services’ includes a specified set of services to be provided to patients who meet eligibility requirements. The eligibility requirements are established by psychiatric assessment and address the needs aspects of the mental disability, whereas the ‘basket of services’ establishes patients’ rights to in a manner that maintains their personal and cultural values. The ‘rehabilitation basket’ of services deals with the major disadvantages patients often face, by providing them with services that focus on building skills and supports in domains such as work, recreation, education, social life and housing to improve their opportunity to pursue valued social roles in the community. Specifically, the ‘rehabilitation basket’ guarantees the eligible patient access to the following services:

1. Employment and vocational services including supportive employment, sheltered workshops and assistance in acquiring vocational skills and competitive employment.
2. Residential services consisting of flexible and needs-tailored support which includes referrals to and financing of accompaniment, training and supervisory services in the framework of independent and protected housing. The actual types of housing consist of independent housing – accompanied by an authorized professional or student worker and group homes that vary in the number of residents and intensity of support. Other residential services for people with greater need for support include assisted living and hostels (group homes) that vary in the degree of support and autonomy. In addition, assistance in rental payments, purchasing of primary equipment, assistance in referral and financing of accompaniment, training and supervisory services is offered.
3. Completion of education, assistance with referrals and financing of Hebrew language classes,

completion of elementary and high school education and support for college education.

4. Leisure activity and assistance with referral and financing of participation in social clubs in regular and special frameworks for social activity and acquisition of social skills.
5. Family support – psycho-education, counselling, training, guidance and support for families.
6. Dental care, assistance with referral and financing preventative and proactive dental care.
7. Case management – appointment of a treatment coordinator who is responsible for implementation and coordination of the provision of all the services provided.

Eligibility, criteria are the right to access the ‘rehabilitation basket of services’ include being at least 18 years old, having a mental disability as established by a psychiatrist or at least 40% disability due to the mental disorder which meets the criteria of the National Insurance Institute. Those who meet these eligibility criteria can apply or be referred to a regional rehabilitation committee to actualize their right to the appropriate psychiatric services.

The regional rehabilitation committee. In accordance with the law, regional rehabilitation committees consist of three workers in the professional area of the provision of medical and social services. The purpose of these committees is to meet with the person who has been referred or has applied for rehabilitation services in order to review relevant material regarding eligibility of the candidate for the rehabilitation services. If found eligible for these services, the committee is charged with collaborating with the person with the mental disability in establishing a rehabilitation plan and selecting services from the ‘basket of rehabilitation services’ that are judged as potentially contributing to the person’s progress with her or his rehabilitation plan and to the achievement of that person’s goals. The person can attend these meetings together with her or his rehabilitation worker, a family member, and/or a friend. If the activities of these committee meetings are appropriately coordinated, they can initiate recovery by fostering genuine dialogue between service providers and service users and the working through of the tensions that frequently exist between needs and rights of the person with a psychiatric disability. In this way, the committee meeting can serve as a mechanism for empowering the service user.

According to the law, these regional rehabilitation committees also carry out collaborative supervision with the service user of the implementation of the rehabilitation plan. At 6-month intervals the committees are required to review the rehabilitation plan and

to evaluate its appropriateness and relevance over time. To ascertain that the rehabilitation process maintains sensitivity to and a respect for the rights of the service user, district appeals committees were established so that a regional rehabilitation committee decision may be appealed by anyone significantly connected to this process within 45 days from the date of the decision.

The Council for the Rehabilitation of Persons with a Psychiatric Disability in the Community. The law mandates the establishing of a Council for the Rehabilitation of Persons with a Psychiatric Disability in the Community. This council is charged with advising the Minister of Health regarding multi-year national rehabilitation policy, the rehabilitation of individuals with a psychiatric disability in the community, the planning of rehabilitation services in the community, and the improvement of the quality, availability, accessibility, and equity of psychiatric rehabilitation services. In addition, the council advises the Minister of Health regarding the development of educational programmes, public relations within the community, the recommendation of changes in the basket of rehabilitation services, the development of a standardized system of evaluating the implementation of the law, and the initiation of research of recovery orientated psychiatric rehabilitation.

In keeping with the law's emphasis on such recovery orientated rehabilitation processes and principles as the integration of needs and rights, empowerment, and holism, it is made up of representatives of several major stakeholders. These representatives include members of such medical and social service systems as psychiatry, psychology, social work, occupational therapy and nursing. These representatives were selected from the professional organization with the largest number of members. Certain groups of service users argue that the central issue of psychiatric rehabilitation is the asymmetry in power between the service users and the professionals who control their lives. They argue that the psychiatric establishment often reinforces this asymmetry rather than resolving it (Jacobson, 2004). These groups of service users also contend that an overemphasis on such medically orientated programmes as compulsory medication may divert funding 'away from more integrated approaches to recovery that require investment in housing, employment, and other social services' (Tomes, 2006, p. 727). Therefore, in order to balance the potential risk of overemphasizing the impairment-caused needs of the service users and to provide active support of their rights, the council includes two representatives of service users and two representatives of family members of service users.

To ascertain that sufficient resources are available for meeting the needs and adequately addressing the rights of service users, eight representatives of the following government ministers are members of the council: the Minister of Construction and Housing, the Minister of Labor and Welfare, the Minister of Finance, the Minister of Education, the Minister of Justice, the Minister of Defense, the Minister of Immigrant Absorption and the Minister of Industry, Trade and Labor. In addition, a representative of the Center for Local Government, a representative of the National Insurance Institute, and three academics who are involved in research and professional education in areas relating to psychiatric rehabilitation in three universities are also members of the council.

According to the law, the council is required to meet at least four times a year. Actually, it usually meets monthly. During these meetings, the council performs the various functions that have been spelled out above. In addition, these meetings can provide an opportunity for a dialogue between the various groups of stakeholders of the psychiatric rehabilitation system. By means of this dialogue, such tensions as those that arise from the interrelations between the needs and rights perspectives on recovery orientated psychiatric rehabilitation can be avoided while the various viewpoints are brought to light.

The impact of the law: Meeting needs and addressing rights. A comprehensive systematic evaluation of the effectiveness of the psychiatric rehabilitation programmes initiated as a consequence of the Rehabilitation of Persons with a Psychiatric Disability in the Community Law has yet to be carried out. However, data routinely collected about the psychiatric rehabilitation services provided by Israel's Ministry of Health indicate that the impact of the law has been generally positive. These data shows that there is a need for such services. About one third of the total number of individuals receiving disability pensions from the National Insurance Institute are individuals with psychiatric disabilities. This is the largest group in Israel receiving disability pensions from the NII. On December 2008, their total number was 62,686 (Aviram et al., in press).

Aviram et al. (in press) have reviewed the impact of the law on the quality and quantity since it was enacted a decade ago. Over the course of a decade, the number of individuals with a psychiatric disability receiving psychiatric rehabilitation services increased four-fold from 4,000 to nearly 16,000. In addition, the number of psychiatric rehabilitation programmes has increased rapidly, reaching 550. The rapid development of services came in parallel and was made possible due to the budget for these services

increasing eight-fold (at constant prices) and becoming a much larger proportion of the total mental health government budget, increasing from 4% to 25%. Not surprisingly, the growing utilization of psychiatric rehabilitation services was accompanied by a decrease in the number of psychiatric beds which declined by 50%, from 1 to 0.5 per 1,000 of the population.

As mentioned above, very little systematic research has been undertaken to evaluate the impact of the law. However, the results of those evaluations that have been completed are consistent with the implications of the routinely collected data discussed above. In one follow-up study of 80,000 people who had been discharged from psychiatric hospitals in Israel between the years 1998–2003 and who had a prior psychiatric hospitalization that lasted more than a year, lower readmission rates were found for those who received psychiatric rehabilitation services since the law was enacted (Grinshpoon et al., 2007). In a recent study, Roe et al. (2010b) compared individuals with a psychiatric disability who received psychiatric rehabilitation services to those with a psychiatric disability who were eligible for psychiatric rehabilitation services and had applied for these services according to the law but had not used them. A total of 1,191 individuals with a psychiatric disability (595 psychiatric rehabilitation service users and 596 non-users), completed face-to-face interviews. Adjusted comparisons of quality of life, general satisfaction and psychiatric symptoms revealed that psychiatric rehabilitation service users had better outcomes than non-users. The former reported better quality of life and greater satisfaction alongside fewer psychiatric symptoms than did the latter.

Limitations and future directions

This paper uses the needs–rights paradox and antinomies to show how the recent enactment in Israel of the Rehabilitation of Persons with a Psychiatric Disability in the Community law has produced recovery orientated psychiatric rehabilitation services. Specifically, it shows how three central mechanisms created by this legislation, the basket of psychiatric rehabilitation services, regional rehabilitation committees, and the Council for the Rehabilitation of Persons with a Psychiatric Disability in the Community, should initiate a dynamic process by which the splitting of the needs perspective from the rights perspective reiterates with the integration of these perspectives to engender the empowerment of the person with a psychiatric disability and to facilitate dialogue between this person and other stakeholders of the rehabilitation system. This dynamic reiterative process should increase the opportunities

of individuals with a psychiatric disability both to gratify their needs and to address their rights. Accordingly, this paper also presents direct and indirect evidence of the generally positive impact of the law on the quality and quantity of the psychiatric rehabilitation services provided by Israel's Ministry of Health. Despite the evidence of the progress that has been made in the provision of psychiatric services as a consequence of the relatively new recovery orientated psychiatric rehabilitation legislation, the law's potential to help individuals with a psychiatric disability to confront creatively the needs–rights paradox and antinomies appears to be challenged by a number of limitations (Aviram et al., in press; Drake et al., in press; Roe et al., 2009, 2010a). The following is a description of some of these limitations and of the attempts that are being made to ameliorate them.

First, while there is general agreement that the law has increased the opportunities, quality of life, and hope of individuals with a psychiatric disability and of their families, the extent to which and the manner in which these services produce desired outcomes and promote recovery is not routinely evaluated. For example, in Austria there are triologue groups (Amering et al., this issue, pp. 11–18) consisting of patients, family members and friends, as well as mental health workers. These triologue groups meet regularly in a separate, outer context to the therapeutic or familial, in order to openly evaluate these services, as well as discuss potential ways forward for the mental health system. Furthermore, little is known about the characteristics of those individuals who use these services, their needs, and whether the manner in which the rehabilitation services is provided actually empowers them while enabling them to gratify their needs and address their rights. Moreover, the continuum of services, which manifests in the various intensity of support, create a flexible system in which people can consume less intensive services as they improve. Indeed, the process of recovery simultaneously influences as well as is influenced by service utilization; which is why more should be researched as to the quantity of patients that feel they have benefited enough from the various services and choose to move on from these services and exit the psychiatric rehabilitation system.

However, a National Outcome Rehabilitation Monitoring Implementation Project constitutes encouraging recent progress in the direction of establishing a system for carrying out routine evaluation of the mechanisms created by the law and of the psychiatric rehabilitation services provided by these mechanisms. The goal of this project is to provide essential, but currently unavailable, updated information about the process and quality of psychiatric rehabilitation service provision and of the effectiveness and efficacy

of the rehabilitation services provided. In turn, this system will also be used to formulate constructive feedback that is tailored to the needs of the various stakeholders and to provide this feedback to these stakeholders.

Second, not all of the services specified in the law are being provided. For example, only a small number of case managers appear to be available. Most of those who are available provide a broad range of not always well articulated assistance to the regional coordinators of rehabilitation services rather than providing case management services to individuals with the psychiatric disability. To ameliorate this limitation, a pilot project within two regions in Israel which includes the training of case managers and the provision of case management services by 30 mental health professionals to individuals with a psychiatric disability is currently being implemented and evaluated.

Third, the services specified by the legislation were proposed on the basis of the available professional, clinical, and personal experience at the time the legislation was prepared (Roe et al., 2007). These services are not accompanied by explicit standards or criteria for selecting them on the basis of the needs, interests and capacities of a person with a psychiatric disability. The law explicitly specifies that these services should be modified and adapted from time to time, but in practice, despite the fact that 10 years have passed since the enacting of the law, no changes have been made in the services.

Fourth, although the number of individuals using psychiatric rehabilitation services has rapidly increased, they comprise less than a quarter of those who are eligible for the services. The reasons for the limited use of the available rehabilitation services and ways of overcoming this limitation should be identified. Keeping with recent literature dealing with the incorporation of new evidence in order to enhance recovery in the psychiatric rehabilitation services (Slade et al., this issue, pp. 1–4), some of the possible ways of increasing the appropriate use of psychiatric rehabilitation services should be implemented in keeping with recent literature dealing with the incorporation of new evidence concerning ways to enhance recovery by means of such services. These include reducing the stigma associated with psychiatric disability, increasing the flexibility of eligibility, and ascertaining that the services be publicized, accessible, and perceived as relevant to the needs and goals of individuals with a psychiatric disability.

Fifth, research has contributed importantly to identifying and guiding the implementation of the psychiatric rehabilitation services by providing methods for identifying and disseminating evidence-based practices. Evidence-based practices in the field of psychiatric rehabilitation include using multidisciplinary teams to deliver the service, focusing on

patients' goals, using a process of shared decision-making, stressing integration into the community, embracing natural supports, and helping people to acquire the skills they need to succeed in environments of their choice (Drake et al., in press). These recovery orientated and evidence-based practised components of psychiatric rehabilitation should be incorporated into Israel's relatively new psychiatric rehabilitation system.

Sixth, while the vision of recovery as a major component and goal of psychiatric rehabilitation services is receiving growing attention in the field of psychiatric rehabilitation as reflected in practice standards and teaching curriculums as well as local jargon, it has not yet been recognized and defined as a primary goal of the psychiatric rehabilitation services provided by Israel's new psychiatric rehabilitation legislation. Recovery includes struggling with the needs–rights paradox and antinomies. Therefore, the law, which was formulated without any reference to recovery, should confront the challenge of adopting the vision of recovery as a central principle to guide the development and implementation of psychiatric rehabilitation services in Israel (Slade, 2009).

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