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Overview of Child and Adolescent Mental Health Services in Israel

Abram Sterne ◆ Basil Porter

The study was funded with the assistance of a grant from Michael and Andrea Dubroff of Massachusetts, USA

RESEARCH REPORT

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Executive Summary

Introduction

The mental health care system in Israel is undergoing a historic reform, which will create a legal entitlement to mental health care and transfer responsibility for the provision of mental health services from the government to the four national, nonprofit health plans. At the request of the Israeli government, MJB is playing a central role in designing and carrying out the evaluation of this reform.

The current report seeks to provide an overview of child and adolescent mental health services (CAMH) in Israel prior to the reform, along with an analysis of how they might be strengthened. The specific goals of the overview are:

1. To review the organization of services in other countries
2. To review the different types of services available to children and their families in Israel
2. To analyze the nature of the staffing of services and of the training provided
3. To explore the organizational relationships both within, and among, the health, social service and education systems
4. To assess the degree to which there is duplication and repetition of services across the different sectors
5. To consider the strengths and challenges of the CAMH system as a whole, as well as those of the individual services, with special attention to the extent to which the needs of the children are being met.

The study used a wide definition of CAMH based on the DSM-IV-R guidelines, which include:

- ***Behavioral problems/Mental illness (0-18 years)***
  - Hyperkinetic problems
  - Emotional problems
  - Conduct problems
  - Eating problems
  - Psychotic problems
- ***Developmental disabilities (0-6 years)***
  - Speech/communication delay
  - Autistic spectrum (including Asperger Syndrome)
  - Motor delay
  - Developmental coordination disorder
  - Sensory integration problems
  - Cognitive impairment (retardation)
  - Somatic problems (chronic syndromes – up to 9 years)

Methodology

Between January and October 2010, a series of in-depth interviews were conducted with some 50 professionals and managers from the health, education and social service sectors. from both the public and private sectors, including nonprofit organizations, as follows:

- Senior representatives of the Ministry of Health (MOH) as well as psychiatrists, psychologists, neurologists, pediatricians employed in the health system
- Directors of school psychology services and school psychologists
- Directors of social services and social workers
- Professors of education, psychology and social work
- Heads of child protection agencies and private therapy organizations, health plan executives, individual practitioners.

Using a structured interview format, the study team examined a range of issues including services provided, team structure, funding, challenges facing the service, intra- and inter-organizational relationships, and their perspective on the overall system of CAMH services in Israel.

Findings

CAMH Services around the World

There is a great deal of variation among countries as to how CAMH services are organized and the extent to which they meet the needs. Overall, there appear to be substantial unmet needs – particularly in developing countries, but also in most developed countries.

The UK is one of the countries with the most developed systems of CAMH services. In the UK, while many different agencies are involved in service provision, there is a specific governmental agency charged with oversight and coordination of the services. This has led to more structured service planning, including attention to the relationship between the more intensive services for those most in need and the less intensive services that reach a broader population group.

Overview of CAMH Service Provision in Israel

In Israel, the MOH is the governmental agency responsible for developing and coordinating mental health services. At the same time, the Ministry of Education and the Ministry of Social Affairs and Services (MOSAS) are also involved in providing some mental health and related services. Accordingly, the degree of coordination among the three ministries around mental health care issues can have an important impact on the extent to which mental health needs are met effectively.

Within the health system, the public providers include the community clinics operated by the MOH and the Clalit health plan, the hospital-based outpatient units and the hospital inpatient units. Waiting times in the public community clinics and the outpatient units tend to be quite long.

Numerous nonprofit organizations also provide CAMH services as do the various health plans. In addition, there are a large number of independent CAMH professionals who provide care privately and/or in conjunction with the health plans.

Finally, Israel has an extensive network of child development centers (CDCs). While their focus is on developmental problems, they do get involved in the diagnosis and treatment of behavioral/emotional problems among children who also have developmental problems.

Training and Staffing

Many of the respondents suggested that professionals throughout the service systems (such as pediatricians, teachers, and social workers) could benefit from additional training on key CAMH concepts and issues. They also highlighted the need to address inter-professional tensions among pediatricians, child neurologists and psychologists as well as the tensions between school psychologists and clinical psychologists.

There were mixed reports about whether there is a general, nationwide staffing shortage in the various professions focused on CAMH care. In contrast, there was consensus regarding a shortage of professionals in the periphery and of professionals sufficiently attuned to the unique needs of the Arab and ultra-Orthodox populations.

Organizational Relationships

Many respondents reported inadequate coordination across the health, education and social service sectors. In addition, within the health system, there were reports of inadequate coordination between the CDCs and the mental health clinics, and between the hospitals and the various outpatient settings. There were also reports that multi-disciplinary teams could be playing a greater role, both within particular organizations as well as across organizations.

Key Strengths and Weaknesses

The main strengths of CAMH services in Israel are that there is universal access, care is provided for extended periods if this is deemed necessary, the professionals are well trained, and largely community-based. There are also a large number of innovative and promising new services at the local level.

One of the main challenges reported is the insufficient investment of resources, apparently due in part to the delays in implementing the mental health insurance reform. That delay was also seen as impairing the linkage between the care of the mind and the care of the body and impeding the development of evidenced-based therapies. Other key challenges included the need for more CAMH training in key professions that interact with children and greater coordination across the health, educational and social service sectors regarding service provision in the field as well as policy development at the national level. Finally, there was a sense that more needs to be done to disseminate successful local innovations.

The study's findings are expected to serve as an important input into efforts to implement the new mental health care reform. In particular, the study provides valuable background information for efforts to increase the availability of high quality services for children, and greater coordination among those services, within the framework of the reform.

The study was funded with the assistance of a grant from Michael and Andrea Dubroff of Massachusetts, USA.

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Preface: The Mental Health Reform and its Evaluation

The mental health care system in Israel is undergoing a historic reform, which will create a legal entitlement to mental health care and transfer responsibility for the provision of mental health services from the government to the four national, nonprofit health plans.

The main goals of the reform include:

- Improving quality through better integration of mental and physical healthcare
- Significantly expanding the availability and accessibility of services (particularly to previously underserved populations)
- Increasing efficiency, in part through the use of managed care techniques.

Alongside the goals, the reform has generated a range of concerns, including:

- The adequacy of funding levels
- The medicalization of mental health care
- The linkages among service systems.

At the request of the Israeli government, MJB is playing a central role in designing and carrying out the evaluation of this reform. A key stage in the process was the convening of a national symposium involving a broad spectrum of mental health policymakers, service providers and researchers to identify the main issues to be addressed in the evaluation (Nirel, 2009).

MJB's multi-pronged evaluation effort addresses many of those issues, including:

- An organization study of how the health plans are mobilizing to implement their part in the reform, including what services they are putting into place, how they are staffing them, etc.
- Provider surveys to monitor professional practices and attitudes
- Consumer/patient surveys to assess access to care and the care experience
- An analysis of changes in patterns of service utilization
- Efforts to draw on the international experience with major mental health care reforms and their evaluation.

Thus, the evaluation will provide information on the implementation process as well as indicators of intermediate and final outcomes, thereby contributing to real-time efforts to refine the reform effort.

1. Introduction to the Overview

The current report seeks to provide an overview of child and adolescent mental health services (CAMH) in Israel prior to the mental health insurance reform, along with an analysis of how they might be strengthened. The specific goals of the overview are:

1) To review the organization of services in other countries
2) To review the different types of services that are available to children and their families in Israel
2) To analyze the nature of the staffing of services and of the training provided
3) To explore the organizational relationships both within, and between, the health, social service and education sectors
4) To assess the degree to which there is duplication and repetition of services across the different sectors
5) To consider the strengths and challenges of the CAMH system as a whole, as well as those of the services that were encountered, with special attention to the extent to which children's needs are being met.

1.1 Structure of the Overview

In the opening section, we define child and adolescent mental health and hence the scope of the overview. We also provide a short review of the epidemiology of child and adolescent mental health problems in Israel. In the last part of the section, we describe the goals, methodology and limitations of the overview. The second section provides a short review of developments in CAMH services in the world. The remainder of the report addresses four themes drawn from interviews conducted with a wide range of mental health professions working in the field of CAMH services: The level of the services provided; training and staffing; organizational relationships; and strengths and challenges. The report concludes with a brief summary.

1.2 Definition of Child and Adolescent Mental Health

We have used a wide definition of child and adolescent mental health based on the DSM-IV criteria, focusing on mental illnesses and behavioral problems, including hyperkinetic, emotional, conduct, eating and psychotic problems.

The paper also gives some secondary attention to the system for addressing developmental disabilities because many children have both types of problems and they interact with one another.[1]

We found that there is considerable debate within the Israeli service system about the definitions of mental health problems. For the purposes of this report, we have included "behavioral" and "emotional" problems among the mental health problems to be considered.

[1] Note that even though Child Developmental Centers in Israel try to distinguish between developmental and mental health issues, this is complicated by the fact that many children with developmental issues also have behavior problems (e.g., children with ADHD and concurrent oppositional behavior).

1.3 Epidemiology of Child and Adolescent Mental Health

Extent of Mental Health Problems in Children and Adolescents in the World

Determining the levels of mental health problems in children and adolescents is a complex task (Belfer, 2008). First, there is the challenge of accurately diagnosing mental health problems, with ICD-10 and DSM-IV classifications having limited cultural applicability in global epidemiological studies. Second, there is a lack of metrics to describe the magnitude of mental health problems among youth in relation to other health issues in terms of economic cost and impairment. In the last decade, a new field within epidemiology has arisen with a focus on child and adolescent psychiatry, which seeks to address the challenges of measuring mental illness in the youth (Costello et al., 2005). ***Developmental Epidemiology*** uses various methods of assessing prevalence of mental illness in children and adolescent, including:

- The development of diagnostic interviews that have been specially designed for children from 8 years and over[2]
- Extensions to psychiatric classification through developing a clear taxonomy of early childhood problems
- The translation of standardized screening and assessment instruments for children and adolescents into different languages.

The first study to use such tools was the British Child and Adolescent Mental Health Survey (Ford et al., 2003), in which 10,438 children were interviewed and assessed through a structured interview. These interviews were turned into verbatim reports that also included information from children, parents and teachers, in an effort to emulate the clinical assessment process. These reports were then reviewed by clinicians. The overall prevalence of DSM-IV problems in children (0-12) was 9.5%, with an additional 2.1% falling into the "not otherwise specified category." For young adolescents aged 13-15 years the prevalence rates increased to 12.2% for a DSM-IV disorder, and 3.6% for a non-categorized disorder.

However, such carefully constructed studies are still infrequent. The consensus based on WHO data and other studies, which use less rigorous research methodology, is that the worldwide prevalence rate for child and adolescent mental problems is 20% (Belfer and Saxena, 2006). There is also discussion of the consequences of mental problems on childhood. Remschmidt and Belfer (2005) list the major consequences of mental problems in young people as: 1) Suicide, which is third leading cause of death among adolescents; 2) Major depression, which in 50% of adults begins in adolescence, and, if left untreated, is associated with substantial psychosocial impairment that is much more difficult to treat; c) Adult crime and antisocial behavior, marital problems, unemployment and poor physical health stemming from untreated conduct problems in children and adolescents. These are but a few of the potential impacts of mental health problems in childhood and adolescence.

[2] For example, the NIMH developed the Diagnostic Interview Schedule for Children (2000).

As with the emotional problems described above, there are also challenges in measuring the prevalence rates of children with neurodevelopmental problems especially in terms of applying sufficiently precise criteria for a range of developmental problems including autistic spectrum disorders, learning disabilities and motor coordination deficits (Andrews et al., 2009). The agreed core feature for neurodevelopmental disabilities is a recognized disturbance in the acquisition and expression of early developmental skills (e.g., learning to walk, speak or play with other children – Shevell, 2009). For the most common developmental problems, international prevalence rates for children up to the age of five are as follows:

- Autistic spectrum problems – range from 4.6 (Nassar et al., 2009) to 6 per 1,000 (Nicholas et al., 2008)
- Language problems – range from 7 (Tomblin et al., 1997) to 13 (McLeod and Harrison, 2009) per 100
- Intellectual impairment (retardation) – 1 per 100 (Allison and Strydom, 2009)
- Cerebral Palsy – 2 per 1,000 (Cans et al., 2008).

Extent of Mental Health Problems in Children and Adolescents in Israel

Before the Israel Survey of Mental Health among Adolescents (ISMEHA) in 2004/5, there was little epidemiological information on children and adolescents in Israel (Mansbach-Kleinfeld et al., 2009; Farbstein et al., 2010). Using similar protocols and tools to the UK survey, the survey interviewed 957 adolescents aged 14-17 years and their mothers across all population groups in Israel. Initial findings suggest an overall incidence rate of 11.7% (13.8 for 100 girls and 9.7 for 100 boys), with a 6% prevalence rate for any kind of anxiety, 3.3% for depression, and 3% for ADHD. There were no significant differences in rates of mental problems between Arabs and Jews. Interestingly, for a country with high numbers of large families, adolescents living with a large number of siblings had lower rates of mental disorder than those living with only one sibling. In addition, the presence of a learning disability was often associated with having a mental health problem. Another important finding from the survey was that 60% of mothers of children with a mental health problem did not consult with any individual outside of the family. It is important to note that, while this was an extensive study of adolescent mental health, there has still been no comparable survey carried out among children up to age 12.

These findings suggest that Israel has similar prevalence rates of child and adolescent mental health problems to the rest of the world. However, since Israel is a relatively young country, there is a greater need for child and adolescent mental health services in relation to the overall population.

1.4 Methodology Used

This overview uses a qualitative approach based on interviews conducted between January and October 2010 with mental health professionals throughout the child and adolescent services. The MOH provided the research team with an initial list of contacts in the health service sector. We then used a simple snowball methodology, in which we asked each

contact to provide us with further contacts. We followed up on these contacts and met with those who responded to an initial e-mail or telephone inquiry.

A series of in-depth interviews were held with professionals and managers from both the public and private sector, including nonprofit organizations, and included:

- Leaders of the MOH and the health plans
- Health care professionals including psychiatrists, psychologists, neurologists, pediatricians
- Directors of school psychology services and school psychologists
- Directors of social services and social workers
- Professors of education, psychology and social work
- Heads of child protection agencies and private therapy organizations, health plan executives, individual practitioners.

We prepared a structured interview that took 45-60 minutes. The questionnaire asked about a range of issues regarding the respondents' own activities including: the services provided, training and staffing, organizational relationships. In addition, the respondents were asked to comment on the key strengths and weaknesses of CAMH services in Israel more generally.

1.5 Limitations of the Overview

We did not set out to collect comprehensive quantitative data, nor to conduct a complete mapping of all CAMH services in Israel. While the people we interviewed represent a broad spectrum of professionals involved in CAMH, there are some gaps, including: Professionals working in the Arab sector, social workers in the field, community mental health nurses, community pediatricians, and service users (children and families using CAMH services).

2. Review of CAMH Services in the World

2.1 Developing CAMH Policy

In 1977, the WHO recommended that every country should have a plan for child mental health, yet there is still a dearth of such national policy initiatives throughout the world. According to the latest WHO survey of mental health service provision, known as the WHO Atlas Project and published in 2005, 78% of high-income countries had a specific child mental health policy in contrast to none of the lower and middle-income countries.

Levav et al. (2004) sent a 12-item questionnaire to government agencies responsible for mental health in 51 countries in the WHO European Region asking about levels of mental health services, the numbers of training programs, and trained child specialists. Among the 36 countries that responded, they found large variances regarding the provision of child and adolescent mental health services, and there was a widely acknowledged gap between the demand for services and what was provided.

In a worldwide review of mental health care provision for children and adolescents, Remschmidt and Belfer (2005) identified some of the gaps, which included:

- Due to the lack of coordinated policy among different government agencies, no single government entity or individual takes responsibility for children mental health programming.
- The funding for child and adolescent mental health services is rarely identifiable in a country's overall health budget.
- 62% of all the countries surveyed in the WHO Atlas (and approximately 80% of countries in Europe and the Americas) lacked a basic psychopharmacological list of medications for children and adolescents with mental health problems, indicating no guidelines for pharmacological treatments of these problems.[3]
- Even with widely recognized problems such as ADHD, the first line of treatment, psychostimulants, was either not available or prohibited for use in 47% of countries in the WHO Atlas Project.[4]

These examples highlight that there are major gaps in policy and service provision, in part related to governmental organizational structure. According to Remschmidt and Belfer, this is true for both developed and developing countries, although mental health provision is worse in the latter.

2.2 Advances in the Development of CAMH Services

There has been significant development in the last 20 years of better-targeted medication for children and adolescents, more pragmatic psychosocial interventions and reforms in service-delivery models (Patel, Fisher, Hetrick and McGorry, 2008). However, these developments have not yet been successfully translated into widespread CAMH services. Patel and his colleagues (Patel, Fisher, Nikapota and Malhotra, 2008) suggest that developing CAMH services should be guided by the following key principles:

- Adopting a holistic mental health framework: that is, a system that promotes well-being in children and adolescents, and not just a focus on mental health problems, and thus needs to incorporate a broad range of stakeholder groups
- Linking capacity development with achievable goals: that is, setting achievable goals and targets in the development of capacity and resources. Creating an implementation plan that uses appropriate technologies and has long-term sustainability
- Building capacity at different levels of the health system: that is, creating a multi-tiered system with fewer specialist in-patient resources, which tend to be more expensive,

[3] Note that the figures in this bullet and the one that follows are averages for the over 100 countries that participated in the Atlas project. The available data on these items do not distinguish between developed and less-developed countries; it seems likely that there would be substantial differences between the two groups.

[4] Unfortunately, data on this variable were not available by region or income level.

and increasing the use of community-based resources which would be more efficient (including teachers, primary care workers, parents and volunteers)

One example of such systemic change is in Australia, with the development of the ORYGEN Youth Health program in Melbourne (McGorry, 2007). Some of the key reforms made in the clinical component of this program include:

- Increasing access to services:
  - Extended clinic hours
  - Mobile multidisciplinary teams providing intensive community-based crisis response
  - Home treatment programs
- Widening the range of interventions including:
  - Psychosocial case management
  - Individual and group therapy
  - Family therapy
  - Vocational recovery programs (e.g., day treatment and rehabilitation programs)
- Developing specialist disorder-specific services for young people with severe personality problems, mood problems and psychoses
- Integrating mental health and substance abuse programs.

In addition to developing and reforming clinical programs, ORYGEN has also developed a comprehensive research program to evaluate outcomes at the individual patient and service levels. Another core component has been to develop a specialist youth mental health training and consultation service for all professionals working with children in the community.

In the USA, a program was established in 1992 to provide community mental services for children and adolescents along the guidelines provided by the Child and Adolescent Service System Program developed in 1984. The guidelines include:

- Individualized programs recognizing the strengths of individual children and their families
- Family inclusion and involvement at every stage of clinical process
- Collaboration and coordination between child-serving agencies
- Serving youth in their communities.

Winters and Metz (2009) describe wraparound programs for children and adolescents that encompass these principles, (in particular the principle of multiagency integration). Currently such services have only been implemented in a few of the states with slight differences in the targeted populations and in implementation. For example, in Oregon, children at risk for serious mental health issues were included in the program in addition to those children with special education needs. The wraparound program in Milwaukee, Wisconsin was designed to service high-risk youth in the juvenile justice system. Some of the major limitations of the

program included a shortage of mental health therapists (especially child and adolescent psychiatrists); lack of inclusion of evidenced-based interventions in the wraparound programs; and the need for significant training of all professionals working with children in the wider community that interface with the program. Ultimately, lack of sufficient funding for youth mental health programs in the US has led to a large gap between levels of need and services provided, with up to 80% of children and adolescents with mental problems not receiving the help they need (Kataoka et al., 2002).

Currently, in the UK, there is one governmental department with responsibility for public child and adolescent services, with responsibility and oversight for health, education and social services. Local authorities deliver these services under the rubric and structures developed by the Department of Children, Schools and Families. In the most recent mapping of CAMH services (Department for Children, Schools and Family, UK, 2009), they describe two service models: a 4-tier health-based model of CAMH services that is incorporated into the wider system (Figure 1); and an integrated system of mental health services across all the services sectors (Figure 2).

Figure 1: Four-Tier Model of CAMH Services in the UK

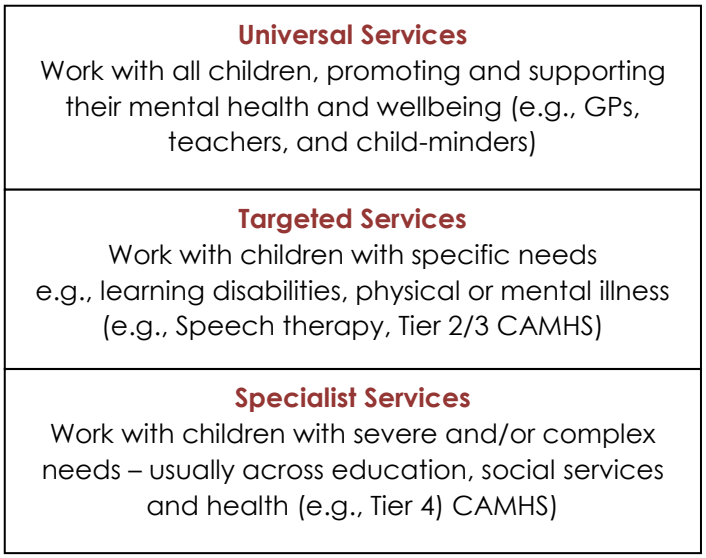
Tier 1 Services provided in the community by practitioners working in universal services (e.g., youth workers, teachers, GPs)
Tier 2 Services provided in the community by specialists with training in mental health
Tier 3 Services provided by a multidisciplinary team working in a community mental health clinic or outpatient department
Tier 4 Services for the most serious cases in specialist residential settings, including inpatient hospital wards

One purpose of the four-tier model is to integrate community and specialist services, and to emphasize that mental health issues are best dealt with in the community. Tier 1 reflects the position that most child and adolescent mental health issues can be simply and quickly resolved by professionals like GPs and teachers who have been given additional training to recognize and deal with simple emotional and behavioral issues. They will also have sufficient knowledge and awareness to make referrals to appropriate agencies for additional support. At the tier 2 level, specialist professionals, such as primary mental health

workers, who may be nurses or occupational therapists with additional specialized training in CAMH work, deal with non-complex emotional and behavioral issues. Typically, they work in local GP practices or other accessible locations in the community. They also act to triage more severe cases to the tier 3 level, which is a specialist mental health clinic for children and adolescents that includes child psychiatrists, clinical psychologists, nurses and social workers. These cases can be severe and chronic, and often require multidisciplinary input. Finally, if complex cases cannot be contained within the community, there is the availability of tier 4 residential or inpatient services to deal with children and adolescents who are at risk of self-harm or harm to others. These services may include specialist units for dealing with problems such as eating disorders.

The four-tier paradigm is also meant to model the idea that more significant levels of resources should be available for mental health at the universal (i.e., tier 1) level rather than the targeted and specific services of tiers 3 and 4. Before the adoption of the four-tier paradigm, the emphasis had been in the opposite direction with greater resources for specialist services, which tended to be health based and not integrated within educational or social service frameworks. Integrating all public service frameworks for children's services has become a paramount goal in UK child and adolescent mental health policy (Department for Children, Schools and Family, 2009), and has led to a recent shift towards the concept of universal, targeted and specialist (UTS) services shown in Figure 2. The UTS model also reflects integration between mental health and all other physical and social services that the public sector provides for children and their families.

Figure 2: UTS Model of Services for Children in the UK



3. Level of Services Provided in Israel

In this section, we present an overview of the range of services provided in the health, social service and educational sectors in Israel. This section does not contain an exhaustive list of all mental services for children available in Israel, but rather a description of the many different programs that were visited or described in interviews with directors and key stakeholders.

3.1 Health Services

Within the Israeli health system, CAMH services are provided in many different contexts, including:

- CAMH community clinics
- Hospital inpatient and outpatient clinics
- Individual practitioners (either privately or through the health plans)
- Child Development Centers
- Nonprofit organizations
- Private sector services.

We consider each of these in turn.

CAMH Community Clinics

The MOH operates 38 CAMH community clinics (*tachanot yeledim v'noar)* throughout Israel, with many clustered in the center of Israel.[5] Typically, these services are managed by clinical psychologists or social workers and employ a range of staff including clinical psychologists, social workers, expressive arts therapists and occupational therapists. Some services employ psychiatrists, but many purchase the services of psychiatrists from the local hospital services. While there are some collaborative ties between these clinics and other educational and social services, they tend to be limited in scope. The resources at most clinics are limited and there has been little development of these services in the last five years, in anticipation of the mental health reform and the transfer of such services to the four health plans. It was reported to us that typically in these services no replacement is found for professionals who leave the clinic.

These clinics provide some assessment of mental health problems, but this does not include any cognitive or neuro-psychometric component. Most interventions are psychodynamically oriented, with typical treatments being focused on the individual child and lasting 12 or more months. Many of these clinics also do some concurrent work with parents. There is very little family therapy work and there are virtually no cognitive-behavioral therapy interventions. There are some expressive arts therapy interventions including art, play, music and dance.

[5] These data were provided by the Department for Mental Health, Ministry of Health.

Many referrals come through the parents themselves, who have often been encouraged by their local family physician, social worker or a teacher, guidance counselor or psychologist in the child's school. These professionals are also able to refer families to these CAMH community clinics. Many families may have to wait several months before an initial assessment and additional months before receiving treatment. All services provided by the clinics are free with no co-payment.

The largest health plan, Clalit, on behalf of the MOH, operates 18 community clinics, as well as a number of hospital-based clinics, mainly in the center of the country, in addition to clinics in Haifa and Beersheva. As with the MOH clinics, many referrals come through the parents themselves, following encouragement from their local family physician, social worker or a teacher in their child's school. These professionals are also able to refer families to these CAMH community clinics. Many families may have to wait several months before an initial assessment and a further several months before receiving treatment. All services provided by the clinics are free with no co-payment. The community clinics operate on very similar guidelines to the MOH clinics, and most treatments are psychodynamically oriented, lasting on average 12 or more months. There is some concurrent work with parents, but limited family therapy interventions, and virtually no cognitive behavioral approaches are used.

Hospital Inpatient and Outpatient Services

Most of the large hospitals in Israel have inpatient or outpatient clinics providing CAMH services. These services are managed by psychiatrists, and typically have staff teams that comprise clinical psychologists, nurses (inpatient wards), social workers, and occasionally, occupational therapists. The inpatient wards are managed by the hospital and funded by the MOH. The outpatient departments are funded through a mix of MOH funding, private philanthropic donations, and research grants. In one outpatient department that was visited, more than 95% of the funding came from charitable sources and research grants.

All the inpatient wards require professional referrals, which can be from the emergency department, the local community/outpatient mental health service, the primary care physician, or the local social services. There is no formal referral system for most outpatient services. Many parents and families self-refer, or are referred by different community services including family physician, school, or local social services.

Some of the hospitals are linked to infant mental health units that work mainly with families and children up to 5 years of age. Referrals to outpatient and community clinics are informal, and mainly parent referrals. The inpatient referrals tend to come from community mental health professionals or via physicians in the emergency department.

Many outpatient clinics have 1-2 month waiting times for initial assessment and then a much longer waiting time for receiving therapeutic treatment. Emergency and severe cases are typically seen within a few days. We were told by some of the directors we interviewed that they often encouraged patients to seek out other services for therapeutic interventions because of long waiting times.

Outpatient departments varied in the range of interventions offered; however, most that offer psychotherapy tended to use psychodynamic (as opposed to behavior and cognitive) approaches with typical treatments lasting 12 or more months. In one outpatient department, cognitive behavioral therapy was the dominant treatment. There was very little family therapy provided in these clinics, although most did provide concurrent sessions with parents.

Individual Practitioners (Privately or through the Health Plans)

Many parents prefer to see private psychiatrists and/or psychologists. This is partly because of the stigma of mental health and the desire to avoid any official record of mental health issues with their child or the family. All of the four health plans provide some limited insurance coverage for families wishing to visit psychologists, with two of the plans offering coverage as part of the basic insurance package, and three plans offering coverage as part of their supplemental packages. Typically, the insurance covers part of the fee for a limited number of psychotherapy sessions per year. There is no limit on access to psychiatry, as long as sessions are focused on psychopharmacological treatment. The health plans also provide training and some level of oversight of the individual practitioners to ensure quality of care.

Typically, psychiatrists provide assessments and diagnoses, and when necessary psycho-pharmacological intervention. Private therapists, typically clinical psychologists, provide psychotherapy, usually of a psychodynamic orientation. There are relatively few family therapy interventions provided in the private domain. At the time that this study was carried out, waiting times for private practitioners were said to be short overall, although in some locations there could be a 1-2 month wait to see a private child psychiatrist.

Child Development Centers

There are approximately 100 child development centers (CDCs) or units throughout Israel. Some 33 of the CDCs are located and managed in large hospitals and funded by the MOH. The rest of the CDCs are operated either by the four health plans or by nonprofit organizations and are located in the community. CDCs are designed to serve two main population groups: children with so called somatic problems (e.g., cerebral palsy, Down's Syndrome) under the age of 18; and children with developmental problems (e.g., motor problems, language problems) until the age of 9 years. CDCs are mainly funded through the health plans' basket of services as defined by law. There is also a network of rehabilitative day centers for children up to three years of age jointly funded through the Ministries of Health, Social Affairs and Services, and Education.

Most referrals to the CDCs come via the mother and child (*Tipat Chalav*) services and kindergartens. Parents can also self-refer, though they will be asked to supply a report from the kindergarten teacher relating to the child's developmental status. Referrals are typically triaged by a pediatrician who decides whether a child needs the multidisciplinary input of the CDC or can be referred directly to a specific specialist (e.g., speech therapy). Typical waiting times for this initial appointment reportedly ranged from 1-3 weeks, although in certain locations in the periphery some families were reported to wait to up to six months.

CDCs offer a full assessment and diagnostic service, often with input from a range of professionals that could include a pediatrician, neurologist, psychologist, speech therapist, occupational therapist and physical therapist. CDCs also employ social workers who may do the initial intake and provide psychosocial support services. Depending on the age and the kind of diagnosis of the child, families can receive substantial support. Until the age of 3, families can receive up to three hours a week of support from the specialty disciplines in the CDC. From the age of 3-6 years, this is reduced to 54 sessions per year, and from 6-9 years, 18 sessions. Recent legislation has provided a considerably expanded basket of services for families of children with autistic spectrum disorder. While recognizing the frequent co-existence of developmental problems and behavioral or emotional problems, the CDC's usually will only offer diagnosis and treatment for these problems when a clearly defined developmental problem exists, e.g., language delay.

Nonprofit Organizations

There are hundreds of nonprofit organizations in Israel that provide free or heavily subsidized mental health services for children and adolescents. These organizations provide health, educational or social services, and target either specific types of problems (e.g., children with intellectual impairment and mental health problems) or identified high-risk populations (e.g., communities in the south bordering the Gaza strip). Some of the nonprofit organizations that we met are described briefly in Appendix II.

3.2 Social Services

Israel has a well-developed social service system that is under the authority of the Ministry of Social Affairs and Services (MOSAS) and includes both community and out-of-home care. These services provide the basic care and counseling services for children and families. In addition, based on an agreement reached in 2000x, MOSAS is also responsible for the care of autistic children.[6]

While it is the MOH rather than MOSAS that has responsibility for mental health care, MOSAS and the social service system more broadly have several important points of contact with the mental health services. These include:

- Children being cared for in the MOSAS system are referred to the mental health system for diagnosis or treatment when it is felt that they may have a specific mental health problem.
- The identification and referral role is particularly important in the case of children living in institutional settings operated by MOSAS where the Ministry has expanded responsibilities for ensuring that the child's full range of needs are met.
- MOSAS operates special out-of-home frameworks for children who are being released from mental health institutions and cannot return to their families.
- Mental health care providers sometimes provide important input to social service providers by giving them vital information on the mental health problems and progress

[6] This section does not discuss the involvement of the educational system, which is covered in a separate section.

of children being cared for in both settings. Similarly, the social service providers sometimes provide important social welfare information to the mental health providers of these children.

- Some children or families have both mental health and social welfare needs. For example, a parent with a severe mental health problem could have a child-at-risk in terms of social welfare needs. In situations such as these, communication and coordination between the MOH and MOSAS systems are particularly important.
- In some settings, particularly those involving adolescents, social workers employed by social service agencies engage in non-psychiatric therapeutic interventions for behavioral and emotional problems, even though this goes beyond the customary responsibilities of the social service sector.
- The interdisciplinary committees that develop treatment and evaluation plans for children at-risk often include professionals from the MOH's mental health service division or its well-baby preventive care system (the Tipat Chalav mother and child clinics).

A full discussion of Israel's social service system is well-beyond the scope of this report, particularly as it is the MOH rather than MOSAS that has responsibility for mental health care. However, as there are important points of contact between the two systems, Appendix I briefly discusses several examples of those points of contact.

3.3 Education Services

The school psychology services are the main framework within the education system for child and adolescent mental health and this section focuses on them. School counselors also play an important role, which is discussed toward the end of this section.

In contrast to many school psychology services around the world, which tend to focus on learning problems and school behaviors, school psychologists in Israel also have an important community-based role in providing some mental health services. There are more than 250 local school psychology services throughout Israel, each of them managed and staffed by licensed school psychologists. Each service is given a wide mandate to develop tailor-made programs and interventions to meet the specific needs of the local population. They are mainly funded by the Ministry of Education with a third of the funding provided by the local municipality.

There is a close working relationship between the central School Psychology Department at the Ministry of Education and each local school psychology service in terms of policy development and procedural guidelines for dealing with a variety of children's learning problems. The central department also supervises the overall system and ensures that each local school psychology service is properly managed and delivers appropriate services. The department also provides continuing education and training, as well as additional funding for specific innovative pilot projects.

The basic set of services provided by the school psychology service includes:

- Assessment of educational need for individual children
- Support and consultancy for the school and teachers of children with learning difficulties and/or emotional and behavioral problems
- Carrying out psychological tests that are then used by interdisciplinary placement committees to try to place children with special educational needs in appropriate settings with sufficient support
- Provision of emotional support in times of crisis and major incidents at school
- Provision of guidance and consultations to the educational staff
- Working at the school-wide level to help develop appropriate policies and programs.

Referrals to the school psychologist are generally made by the school principal or kindergarten teacher. Waiting times depend on the resources available in each locality. In a well-resourced school psychology service, a typical waiting time for an initial assessment may be 1-2 months. Assessments are not designed to provide diagnoses, but rather to evaluate the child's level of school functioning.

Each school psychologist is assigned a set of schools to foster the development of close collaborative work. In general, more support is available to kindergarten and elementary school children, as psychologists are spread more thinly across high schools with a large number of children. However, counselors are more likely to be found in high schools that provide frontline assistance to children with emotional and behavioral problems.

In many of the school psychology services that we visited, short-term therapeutic interventions were offered for mild to moderate mental health problems (e.g., anxiety). These interventions typically lasted no more than six months, and tended to be either cognitive behavioral therapy (CBT) or play therapy oriented. The sessions took place in school psychologist centers and were usually free of charge. In one location, a more comprehensive therapy center had been developed, with each of the school psychologists giving additional time from their working hours to provide therapy. In this center, the first four sessions are provided free of charge, with the subsequent sessions being charged on a sliding scale.

School counselors are employed by the school and are part of the general staff team reporting to the principal. They are not supervised by the school psychology services, although they are supposed to have close working relationships. Sometimes, a school counselor will provide short-term therapeutic support and refer to the psychology services.

In addition to the basic services discussed above, some schools have initiated a variety of innovative programs. For example, in one local school psychology unit that we visited, there were virtually no mental health services provided in the local community, and the school psychology service took the initiative of offering an extended option for family therapy. Another program ensured that all school psychologists in a certain area received extensive family therapy training so that they could provide better assistance to parents and families.

All of the services we visited reported extensive collaborative links between school psychology services and the local social service offices, especially in terms of developing prevention programs such as parent training programs. In one locality, we encountered a collaborative program between the school psychology service and the local child protection service in providing a program for children who had experienced sexual abuse.

4. Training and Staffing

In this section, we describe some of the central training and staffing themes raised by the individuals who were interviewed. These issues include:

- Stigma associated with mental health throughout the health, education and social service systems
- Insufficient or inadequate mental health training for a wide range of professionals who work with children
- Competition among the different professions
- Numbers of professionals available within the public sector
- Public vs. private sector employment
- Level of professionals for specific population groups.

We shall consider each of these in turn.

4.1 Stigma Associated with Mental Health

Most of the professionals who were interviewed commented on the high levels of stigma associated with mental health problems in general, and especially in the ultra-Orthodox and Arab populations.

4.2 Insufficient or Inadequate Mental Health Training for a Wide Range of Professionals who Work with Children

In each of the main public service sectors we were informed that there was great ignorance of mental health issues among professionals working with children.

Health

Within the health sector, many people told us that physicians and other medical staff in the general health system (i.e., those who are ***not mental health specialists***) receive virtually no training about mental health issues in children or adolescents. This includes pediatricians and child neurologists who deal with behavioral and developmental problems including ADHD and autistic spectrum disorders. Some psychiatrists were concerned that children's behavioral problems such as ADHD were mainly being seen by highly-specialized medical professionals who often do not take sufficient account of the familial and psychological context of the child. However, a recent initiative of the MOH has trained a group of community pediatricians in the diagnosis and management of ADHD. This will hopefully reduce many of the referrals to tertiary hospital-based neurology and psychiatric services, with only the more severe cases needing such referrals.

There was also a strong feeling expressed to us about the large number of ***mental health professionals*** who have what are considered to be old-fashioned ideas about mental health and the interventions deemed most appropriate for children and families. In particular, both social workers and individuals within the educational system felt that there was insufficient cognitive behavioral therapy (or other short-term therapy interventions) or family therapy. This was linked to the restricted training of clinical psychologists within Israel who tend to be exposed predominantly to psychodynamic approaches.

Education

All the school psychologists we met told us of a dearth of knowledge about mental health among teachers and school staff. It is thought that this is connected to reluctance among many teachers to deal with challenging behaviors and emotional problems

Some of the clinical psychologists and psychiatrists whom we interviewed were concerned that some school psychologists themselves did not have sufficient training or in-depth experience in dealing with mental health issues. They contended that one result of this was reluctance on the part of the school psychologists to refer children with ADHD to mental health services. In response, school psychologists told us that there were two main reasons for not sending children with suspected ADHD to mental health clinics: firstly, they have long waiting lists and limited resources; and secondly, there is less stigma attached to referrals to pediatricians or child neurologists. In general, school psychologists do not have the time to provide direct therapeutic intervention for many children, and they see themselves as a filtering system for passing on children with more severe mental health problems to other, more appropriate services.

There is seldom an effective line of communication between the school psychology service and the primary care pediatrics service. Thus a child may be referred to mental health services without any coordination between the educational system and primary care providers regarding the nature of the problem and the perceived needs for intervention. If the child is under the age of 6 years and has been seen in a CDC, there is a better chance of coordination between the education and health sectors.

Social Services

Most social workers receive some instruction about mental health issues as part of their social work training. However, many of the social workers on the frontline with children are relatively inexperienced and overburdened with high caseloads, so that they do not have opportunities for in-depth development of their skills and knowledge. We were told that while there were many excellent innovative programs within the social service sector, there was a lack of a clear concept of treatment, and a lack of evidence-based knowledge among social workers in the field. Another issue raised was that of insufficient supervision for social workers in the field regarding mental health problems within the families with which they were working.

4.3 Conflict among the Different Professions

It was reported to us that there were many conflicts among the different disciplines working in CAMH services, some of which have been indicated in the previous section. In particular, two professional conflicts were mentioned: 1. Pediatricians/child neurologists and psychiatrists; and 2. School psychologists and clinical psychologists.

Pediatricians/Child Neurologists and Psychiatrists

Many psychiatrists expressed concerned about their role within the medical system, as many of the behavioral problems that they would be expected to deal with are now covered by CDCs, which are typically operated by pediatricians. At the heart of this conflict lies the failure to implement the transfer of responsibility for mental health care from the government to the health plans. This stagnation and the resulting uncertainty about the future organization of mental health care in Israel has led to a situation where psychiatrists are not being allocated sufficient time and resources to develop services to meet the changing needs of the child and adolescent population in Israel. The failure to include mental health services in the framework of the National Health Insurance Law of 1995 has resulted in an increasing divide between the general and mental health sectors. Parents with a child with behavioral or emotional issues may have to choose between the services of school psychologists if available (psychologists belonging to the health plans) or MOH mental health clinics, with minimal or no involvement of the primary care pediatrician.

The primary concern of psychiatrists is that the expanded role of pediatricians and pediatric neurologists has come with no additional training in mental health. The concern that was expressed was that behavioral problems were seen as biologically based and needing biochemical solutions. Psychiatrists and psychologists have extensive training in the bio-psychosocial model of mental health and have knowledge and experience that is seen as critical to understanding behavioral and developmental problems. Conversely, the concern among pediatricians and pediatric neurologists is that the mental health system is, in general, out of touch with the latest therapeutic approaches to dealing with behavioral problems, and has an associated stigma that means that many families would not seek help from psychiatrists.

School Psychologists and Clinical Psychologists

According to the clinical and school psychologists who were interviewed, there is often rivalry between the two professions. Many school psychologists feel that clinical psychologists work in too rigid a manner, with too great a focus on individual work with the child. In general, clinical psychologists only work within a CAMH system, either in hospitals or in the community clinics, or in private practice. The opinion was expressed that clinical psychologists mainly use a psychodynamic approach, and tend to stay within their clinics with little time or inclination to meet with other professionals within the community. It was also claimed that clinical psychologists tend to separate the emotional and mental problems of children from their developmental and learning issues that are often concordant.

On the other hand, clinical psychologists expressed concern about whether school psychologists were really sufficiently trained to provide therapeutic interventions, particularly in situations requiring emergency responses.

4.4 Numbers of Professionals Available within the Public Sector

In all of our interviews, we asked whether there were sufficient numbers of mental health professionals in the different fields. We were told that there were about 150 fully qualified child psychiatrists in Israel, which, for a population of 2 million children, means that there is one psychiatrist for every 13,500 children. The vast majority of mental health professionals said that there were not enough child psychiatrists, especially in the periphery of the country, and for special population groups. However, there were some child psychiatrists who expressed the opinion that there were sufficient numbers of mental health professionals (including psychiatrists), but they were not deployed effectively, leading to a situation where there are insufficient services despite enough trained professionals.

Again, there was a mixed response to the question of psychologists. Many felt that there were enough trained clinical and school psychologists, but that they tended to leave the public system for the private sector very quickly because of poor work conditions. However, a number of psychologists we interviewed told us that there had been a gradual reduction in the number of training scholarships available, which meant that fewer clinical psychologists were completing their training, leading to an even greater shortage of clinicians available for work in the public services.

4.5 Public vs. Private Sectors

We interviewed several psychologists and psychiatrists who worked concurrently in both the public and private sectors. All of the respondents expressed a wish to work primarily in the public sector, but now mainly worked privately. This was chiefly due to low salaries, particularly for clinical and school psychologists, in the public sector. In addition, many of the respondents felt that they received insufficient supervision and continuing education training. Some told us that they had left because the resources in the public sector were poor and getting worse. All felt that insufficient resources were being invested into the system, and that there had been virtually no development of mental health services in Israel over the last decade. One psychiatrist told us that whenever someone left the CAMH clinic she worked in, the position was frozen and not filled. As a result, more pressure was placed on an ever-decreasing staff, and this led to her decision to leave, even though she knew that there was huge and growing public demand for CAMH services.

4.6 Levels of Professionals for Specific Population Sectors

Arab Sector

Virtually all mental health professionals talked about the lack of Arabic-speaking or Arab psychologists and psychiatrists, which means that the clinical responsibility for mental health issues often falls to either nonprofit organizations or the school psychology system within Arab cities and towns, rather than MOH-based services. Even in these services, we were informed that it is a challenge to recruit appropriately qualified staff. In addition, when no

Arab speaking mental health professionals are available, there are insufficient resources for the use of interpreters across all public services. This means that when Arab families seek help, they have to make do with Hebrew, even if the children themselves are not fluent in Hebrew.

We were told that the MA professional training programs for psychologists have standards that many individuals going through the Arab educational system are unable to meet. There has also been a recent reduction in available training placements making the competition for such places even fiercer, which puts the minority groups at a disadvantage. Many of the respondents also told us that the stigma associated with mental health is greater in Arab populations, and therefore many of the brightest students are not interested in studying psychology or psychiatry.

Ultra-Orthodox Sector

We were told about some of the cultural complexities of treating children and their families from the ultra-Orthodox sector. These include: Requiring a stamp of approval from the local rabbinical authorities; a preference for many to converse in Yiddish; the stigma of mental health issues, especially with regard to marriage prospects; and little access to the general culture of Israel.

The directors of services were asked whether they provided special clinical services for ultra-Orthodox families. Virtually all of them told us that they lacked resources for this population group. We visited one school psychology service in a town that was completely ultra-Orthodox and were told that there were no nearby community-based mental health clinics for children and adolescents from this population group to whom they felt comfortable sending referrals.

While there is growing recognition within the ultra-Orthodox communities of mental illness and the importance of treatment, there is a strong feeling that most CAMH services are not sensitive to their culture and specific needs. One way of dealing with this issue is to train more ultra-Orthodox mental health practitioners. However, this would require specialized training courses for individuals who have little college or university training, which is unlikely, given the requirements of the various mental health professions. Several efforts are underway to address this issue.

The Periphery

There was widespread agreement that there are fewer mental health services available in the periphery, in the north and south of Israel. The most common reason given for this disparity in provision of services was a lack of available mental health professionals to work in these regions in Israel. This is especially the case for child psychiatrists.

5. Organizational Relationships

We asked each of the directors of services about their organizational relationships both within and among the different service sectors including: health, welfare and education. Section 5.1 focuses on inter-organizational relationships, while the rest of the section deals with relationships within organizations.

5.1 Inter-Organizational Relationships

As can be seen from Section 3 above, there is a complex network of services in Israel that provides support for children with emotional, social and psychological problems. We asked all the respondents to tell us about the inter-organizational relationships between their service and other local or national organizations dealing with mental health issues. One overarching theme that emerged was an almost complete lack of integration, coordination and cooperation among these agencies, at both the local and national levels. This was seen as endemic to the whole CAMH system, and it was noted that there were times in which collaboration was actually prevented by the system. We were given an example of this regarding an innovative project that attempted to offer psychiatric services within a specialist school setting for children with emotional and behavioral problems. However, the local education department decided that psychiatrists would not be allowed to operate clinics within the schools and thus could not prescribe medication.[7] This meant that children and their parents had to be referred by the psychiatrist in the school to a colleague in the local hospital for medication. The project did not last long, apparently in part because psychiatric services could not be provided within the schools.

We found that the nonprofit organizations tended to report to us a greater level of collaboration and cooperation with other organizations. This makes sense, as these organizations depend on collaboration with different agencies for funding specific projects such as specialist kindergartens (Ministry of Education), and after-school clubs (MOSAS).

The examples of across-agency collaborative work that were mentioned to us tended to be individual cases and not mandated by either a legal or a policy framework. Thus, they were almost entirely dependent on certain individuals making personal efforts, and were liable to break down when that individual left the service.

A representative from MOSAS described the main challenge for creating collaborative work practices as a lack of definition about mental health problems, which led to turf battles about who should pay for such services. This meant that no one was willing to take responsibility for the whole system. Another respondent from the Ministry also felt that there was a lack of shared language and understanding between professionals in the social and health services, and hence an inability to understand each other's roles and systems. This contrasts with the situation in the UK where there is extensive inter-sectorial collaboration.

5.2 Collaborations within Sectors

Collaboration within the Health Sector

It was reported that there was little collaboration within the health sector for children's mental health issues. We met with the director of child and adolescent mental health at a large hospital in Israel, who told us of "fractionated services, in which there are many mental health workers in many different departments (i.e., even within the same facility) but not

[7]We note that there may well have been sound legal, pedagogical or other reasons for this decision.

working together as one team." He suggested that one reason for this was that the funding for all these posts came from different sources.

There also tend to be poor or non-existent relationships between child development centers and mental health clinics both in hospitals and in the community. There is one major exception to this: the recent development in the last ten years within the Clalit system of infant mental health (this will be described in more detail in Section 6.2, below). In the seven infant mental health clinics there is very close collaboration between the psychiatry and pediatric departments for children with developmental problems. However, in other CDCs, we were told that there were no formal guidelines or procedures for working with the mental health system or for addressing mental health problems.

Some respondents told us that there was poor collaboration between inpatient and community outpatient settings. The exceptions to this tended to be where the same organization operated hospital and community services. We were told about the challenge in organizing appropriate community mental health services for children and adolescents leaving inpatient settings. This is particularly the case for children and youth returning to outpatient services in the periphery.

We were also told by professionals within the social service sector that there was little integration with services for children and adolescents with emotional or behavioral problems. The implementation tended to be haphazard for different levels of services for children with emotional and behavioral problems, with insufficient services in the periphery of the country. This meant that finding the correct setting for a child that appropriately targeted his or her level of need was often a challenge, and too often, children were being given interventions that were based on what was available in the region rather than what they actually needed.

Of course, this situation – of insufficient access to the full spectrum of services – is not unique to mental health services for children; it is a characteristic of the social services in general, where current resource levels are insufficient to meet needs. It is also important to note that the situation may be improving somewhat, as in recent years there has been a major effort to develop community-based services for children in need.

Collaboration within the Education Sector

The education sector is a lot more simply organized than the social service and health sectors. Each kindergarten, elementary school and high school has an assigned school psychologist from the local school psychology service. In general, the provision for kindergartens and elementary schools is much better, with lower psychologist-to-child ratios than in high schools. However, most high schools have a counseling service that provides some emotional support to children with mild to moderate mental health difficulties. Nevertheless, there is insufficient coordination between counselors who are employed directly by the schools and report to the principal, and the school psychology service, which also offers limited therapeutic intervention. One school psychologist interviewed wondered whether it would be better to integrate these services.

5.3 Overlap of Limited Resources

Given that most respondents talked about a lack of sufficient integration, we asked them whether they saw any overlap and/or duplication in the services that were provided. There are many different kinds of services and options for treatment of mental health problems across the health, education and social service sectors. Thus, having more than one provider available does not necessarily constitute a problem with the way services are organized. Rather, it could reflect healthy competition or the treatment of problems from a variety of different perspectives. The situation becomes problematic if a specific child is being treated for the same problem in a similar way in more than one framework. An example of inappropriate overlap might be a child seeing two psychologists at the same time for the treatment of depression; one through a local mental health clinic, and another through the after-school project run by a joint social service/education program.

While many of the individuals interviewed could see the potential for overlaps in services, especially given the lack of inter-agency coordination, they did not think that this happened often. The main point made by most of the respondents was that there are simply not enough resources being deployed for there to be widespread overlap and duplication of mental health services.

However, many psychiatrists did talk about duplication of similar services provided for a child with developmental and/or behavioral problems. The classic example was a child with ADHD, who might be receiving support for behavioral problems from the school psychology service, a diagnosis from the child development center, and therapy or some other intervention from the mental health service. Still, in practice, it should be stressed that none the respondents thought that this was a common occurrence.

We were also told about professional duplication among pediatricians, pediatric neurologists and psychiatrists in the assessment, diagnosis and treatment of children with a variety of developmental and behavioral problems. However, whether this is an example of healthy competition or poor use of resources is debatable. Certainly, according to many pediatricians and school psychologists interviewed, the preference of most families was to first see pediatricians and neurologists rather than psychiatrists. More complex cases would in any case be referred to child and adolescent psychiatry.

There was some agreement between school psychologists and pediatricians that there is a degree of overlap, and hence confusion among families, with respect to who provides psychological testing and in which settings. It appears that the type of psychologists administering the tests tends to vary across settings: School psychologists predominating within the educational framework; clinical psychologists within the mental health clinic or hospital framework; developmental psychologists within the child development center; and rehabilitation psychologists and/or child neurologists in pediatric neurology departments.

Another possible area of service duplication that was described to us was between education and mental health services provided to children with emotional and behavioral problems. It is possible for children to be receiving therapeutic services from both a CAMH

clinic and the school counseling services. However, the prevalence of such duplication of services depends on the extent of local funding for either school counseling services or the school psychology services to provide therapy for children in schools. In one area that we visited, there was additional funding from the local authority for the school psychology service to provide therapeutic interventions. In some areas, this could have led to a problematic overlap with what health-based mental health services are meant to provide. However, in this particular case, there was no problematic overlap as there was no community mental health clinic in that area.

5.4 Referrals in the Israeli CAMH System

The vast majority of the mental health services visited in the study had no standard referral form or process, with most directors preferring a more flexible approach for receiving referrals. This obviously has implications for the way that different provider organizations interact with one another regarding the care of individuals in need. It also has implications for the interface between the individual in need and each of the relevant care providers.

While most community mental health clinics reported waiting times of several months for initial assessments and for treatment, we found that there was no systematic method for triaging the many referrals that are received; this adds to the waiting time pressures. In addition, the directors told us that little effort is made to ensure that referrals are made appropriately, although in many services there is a person who does an intake screening of referrals. There are no local or national guidelines for professionals in the community for knowing which children need to be referred to specialist services or how to make appropriate referrals.

There are many points through which children and their families can enter the mental health service system in Israel. The main sources of referrals include:

- Mother and child services (*Tipat Chalav*): All infants in Israel are served by a network of mother and child clinics in the first years of life, where they receive their immunizations, nutritional counseling and guidance regarding normal child development. When problems arise around issues of abnormal behavior (e.g., excessive crying, sleep problems or tantrums), the child may be referred to one of the following for consultation: Primary care pediatrician, CDC, or a community mental health clinic.
- Primary care services: Children and families are seen either by general primary care physicians or by community-based pediatricians. There is growing expectation that such community pediatricians should be able to deal with a range of behavioral issues (Oren et al., 2011). However, in practice, few pediatricians take on dealing with these problems, either because of inadequate training, or due to time constraints in busy clinics.
- Child development centers: Many of the children referred to a CDC have mental health problems, which is indicative of the high correlation between mental health and developmental issues. Typically, such behavioral or other mental health issues are referred to mental health services in the community (Haggerty, 1994).

- Schools and school psychology services: Although many children receive therapeutic interventions from school-based counselors and support for behavioral problems from school psychologists, these services do make referrals into the CAMH system. These tend to be for severe mental health conditions or for the purpose of assessment and diagnosis (e.g., ADHD).
- Social service department services: Local community social workers are often on the front line of dealing with social, emotional and psychological problems, especially for issues of suspected family violence or child abuse. While many of these cases are dealt with through the social service framework, as described above, many referrals are made into the CAMH system from social workers seeking intensive therapeutic or psychiatric intervention.
- Parent or family-based referrals: Most referrals come from parents and families themselves with concerns about their children's emotional and mental health. Many parents are typically encouraged by community professionals (e.g., teachers, social workers, the primary care physician) to refer themselves to mental health or other services. (Given the widespread stigma regarding mental health, the expectation that parents should refer themselves for support may have led to a situation in which relatively few parents in Israel use such services.)[8]

5.5 Use of Multidisciplinary Teamwork

In general, we found only limited use of multidisciplinary teams (MDTs) working across, or even within, the social, educational and health systems. Many teams did have different disciplines working within a clinic, but there was little collaborative work across the professional boundaries. The one major exception to this was in the CDCs, where there was widespread use of MDTs that included pediatricians, psychologists, occupational therapists and speech therapists.

We were told that the social service system mainly employs social workers and expressive art therapists. Within the education system, school psychology services only employ school psychologists. Within the mental health system, the majority of services include clinical psychologists, psychiatrists and some social workers, but with little collaboration among them. Some mental health clinics did have other disciplines as part of their staff team such as expressive art therapists or occupational therapists, but they typically operated with a narrow focus.

5.6 Innovation versus Systemic Change

One other organizational theme that was raised by several respondents was that of innovation versus systemic change. There are many examples of innovative services being developed for children and adolescents with mental health problems, some of which are be described below. However, the pioneers who develop such services tend to find it a challenge to integrate new ideas and services into the overall system, so that innovation

[8] For a discussion of this issue, see page 43 of Mansbach-Kleinfeld et al., 2009.

leads to the system becoming more fragmented. This happens frequently at the local level across the health, education and welfare sectors. The individuals who raised this issue felt strongly that it was important to implement innovations in the treatment of childhood mental illness more systematically. This means creating system-wide change through the development of shared policy and language across all the public service ministries. This was seen as critical to avoiding the inevitable disparities of service that local innovation creates, and to create a mental health system that works synchronously across all public service sectors.

6. Strengths and Challenges

In this section we report on some of the strengths and challenges of the CAMH services that were described by respondents regarding:

- Current CAMH services available in Israel
- Examples of innovative services
- Vision for the future.

We consider each of these in turn.

6.1 Current CAMH Services Available in Israel

Strengths

CAMH services provided in the public sector are free. While there are often long waiting times, the provision of services can be very generous. Children who need long-term therapeutic intervention can receive such services for many years if deemed necessary. Several respondents noted that, in general, the public CAMH services have a cadre of highly trained staff. For example, in addition to the general training in psychiatry, child psychiatrists also receive high quality training in child psychopathology and treatment. Clinical psychologists also have high levels of training with many years of experience and supervision before being qualified.

Most CAMH services are based in the community, facilitating easier access and less stigma than in hospital-based services. In addition to the health-based services, there are comprehensive school psychology services throughout Israel. School psychologists are community-based professionals working in schools who often work closely with the social services. School psychologists are also flexible in terms of the range of problems they address that go beyond school related learning and classroom behavior. We met with teams of school psychologists who were trained in systemic (family) therapy techniques, solution-focus therapy skills and narrative therapy – all of which are modern child-focused interventions. It is easy for families to access their services through the school or directly. These services are readily available to school and kindergarten staff for consultation as well.

Social services for children and adolescents with mental health problems are mostly community based and are comprehensive in their range. They are oriented primarily towards children's overall social needs rather than focused on their pathologies and it is now

common practice for social workers to develop understanding about the system context surrounding each individual child.

All these different service contexts provide important opportunities for trainees from the different professions to learn skills and gain experience in child and adolescent mental health.

Challenges

The most common theme raised by the respondents was the delay in the transfer of responsibility for mental health services to the health plans, which would then be incentivized to develop better services. Many of the respondents felt that this was a necessary process for CAMH within Israel, and that overall it would improve the system. The current status quo was described as being paralyzed by insufficient investment of resources, and a lack of desire to develop policy for CAMH services.

A few respondents felt that the CAMH system should be reformed without transferring responsibility for mental health to the health plans. They expressed concern that doing so would lead to a rationing of services and an end to long-term therapy.

Connected to this reform is the challenge of the current system being separated from the medical system in general. Indeed, some respondents commented on the separation between body and mind within all public services, and noted that compartmentalization leads to poorer interventions for children and adolescents. There was also hope that mental health reform would commit CAMH services to using much more evidence-based practices, and it was noted that there is currently a lack of systemic/family therapy interventions, and cognitive behavior therapy.

Nearly all the respondents talked about the lack of a clear policy for the development of mental health services across the public sector. There was a widespread call for the MOH, MOSAS, and the Ministry of Education to work together to coordinate and integrate CAMH services. This includes creating procedures and guidelines for managing inter-agency relationships (with agreed standards, such as for waiting times, length of treatment, and the definitions/coding of diagnoses). In order to improve coordination between disciplines and agencies, there is clearly a need for a common language regarding the definition of CAMH problems. This applies to the mild high prevalence problems, such as temper tantrums or excessive crying in infancy, through to the more severe psychopathology encountered in the CAMH realm, such as ADHD, autistic spectrum or ODD (oppositional defiant disorder). It seems obvious that agreement on definitions for these conditions will be helpful both at the individual clinical level and for epidemiologic and health services planning issues. Many respondents spoke of the need to develop a shared language for mental health to facilitate better understanding and working relationships across the public service sectors.

Another concern raised by some of the respondents was that at the MOH headquarters there is no specific professional focused on child and adolescent mental health. Some

respondents opined that this may be contributing to a general feeling of a lack of interest and support to this area of health services.

It was also suggested that it would be better to split CAMH services by age groups into three service areas, so that there would be better representation for infant and child mental health services:

- Infant mental health (0-5 years), which would be fully integrated in the child development centers
- Child mental health (6-11 years)
- Adolescent mental health.

Each of these areas presents a set of unique problems with implications both for individual management and for health services planning. The infant with excessive crying or sleep issues will be common in the first group, school related learning and attention problems will dominate the second group, while in adolescence, issues of self-esteem, acting-out behavior and substance abuse will be the focus. It was felt that such a split in the services would also promote better representation at governmental levels for these chronically underfunded services. In addition, splitting these services would help to develop expertise and better targeted prevention and treatment programs. On the other hand, any such separation would require mechanisms for insuring continuity as children move across the age groups, such as a requirement for representatives of both groups at a summary meeting before a child moves to the next group.

Many respondents also were concerned about the lack of specialist treatment units for problems such as eating disorders, borderline personality problems and self-harm. Again, the opinion was expressed that creating specialized services for the different age groups may lead to the developing of specific services for severe mental health problems.

There was widespread concern about the stigma associated with mental health both by the general public and among professionals working with children. The opinion was expressed that this was an issue that needed to be dealt with at the national level, with all the public services working together to promote better understanding of mental health issues, and to develop specific in-service training on mental health for a broad range of professionals working with children. Related to this was a demand for greater cultural sensitivity, which is seen as integral to successful outcomes in mental health intervention.

6.2 Examples of Innovative Services

In this section, we describe briefly some of the innovative services that we encountered in 2010 when interviewing respondents for the overview.

Infant Mental Health

One example of an innovative service was the development of a network of seven infant mental health services within the Clalit health system, pioneered by Dr. Miri Keren. In many ways, this reflected the growing scientific evidence and awareness of the importance of

early childhood development for long-term mental health. The service provided assessment, treatment and consultancy on a wide range of early childhood emotional and behavioral problems that include: toilet training issues, aggression, extreme shyness and communication problems. The emphasis was on working with the whole family together and supporting the development of good parenting skills. The service was developed in conjunction with the MOH, Clalit and the Sacta Rashi Foundation. It was received very positively and was widely used in the child development field, although it was originally an unrecognized area of need.

The Rosh Ha'Ayin CAMH Service

We met with Yoram Medar and members of his team who were implementing an integrated mental health service providing clinical and school psychology interventions for children aged 0-18 years. The service was based in Rosh Ha'Ayin and school, clinical and developmental psychologists worked together with other mental health professionals such as expressive art therapists and social workers. They had a close working relationship with the Geha Psychiatric Hospital CAMH team, which allowed them to have access to a child psychiatrist as part of the multidisciplinary team. The funding was provided by the Ministry of Education, the local municipality, and Clalit through Geha Hospital, and was a good example of collaborative working among different public sector systems.

Pilot Program of the Ministry of Education: Webster-Stratton Parent Training Courses

From 2008-2010, the Ministry of Education in collaboration with the School of Education at Hebrew University implemented a pilot parent training program in 70 kindergartens throughout Israel. Parenting programs have long been seen as important mental health preventative interventions and ways of encouraging community engagement between parents and primary care workers. Many of the parent training groups are co-facilitated by local kindergarten workers and school psychologists as ways of developing skills, knowledge and experience of common emotional and behavioral problems. The pilot program used a culturally adapted version of the internationally acclaimed Webster-Stratton parent training courses that has substantial research showing its efficacy in reducing parent-child conflict and improving children's emotional and behavioral problems. The Ministry of Education provided initial funding for the project.

Dyadic Therapy Intervention for Young Children and Their Parents

We met with Hanna Kaminer, a clinical psychologist who was the director of the Center for Developmental and Psychological Treatment, which was based in Haifa and funded by the MOH. This family-oriented service provided an infant mental health dimension in addition to the typical services of a child development center. In particular, the center developed four main innovative programs: short term parent-child (dyadic) psychotherapy aimed at resolving family conflict and/or dealing with post-traumatic stress; play groups with parents and children that were aimed at parents who had poor attachment relationships with their children; training programs for the professional community to help develop parenting skills; and a prevention intervention with pregnant and post-natal women considered to be "at-

risk" of developing poor relationships with their newborn infant. This was funded by the MOH and an organization called *Mutav*.[9]

Mental Health Service for Children with Intellectual Impairment

We met with Dr. Mike Stawski who was managing a specialist service for children with dual diagnosis (i.e., mental health problems and intellectual impairment) at the Schneider Children's Hospital, and community clinic in conjunction with Beit Issie Shapiro in Ra'annana. His small team consisted of a psychiatrist, occupational therapist, speech therapist and psychologist. This service was started in 2003, and at the time there were virtually no other similar kinds of mental health services for children with intellectual impairment. Much of the work in addition to psychopharmacology was providing support for the family, typically through behavioral approaches. They also worked closely with specialist education establishments and provide consultancy for a variety of behavioral and academic problems. The funding came almost entirely through private donations.

Integrated Hospital and Community Service

Hadassah Medical Center operates a comprehensive child and adolescent mental health system that includes inpatient beds, outpatient clinics, day treatment rehabilitation and a community-based clinic in Jerusalem. We met with Dr. Esther Gallili, who was the manager of this service and who told us about the many different specialized clinics and interventions they provided for children and adolescents. These included: a trauma center, ADHD clinic, learning disabilities center, eating problems clinic, infant mental health and a crisis

6.3 Vision for the Future

We asked all of our respondents to share some of their visions for the future of child and adolescent mental health services in Israel. The main themes can be divided into four categories:

- Policy development
- Organizational change
- Improved and increased training
- Enhanced clinical interventions.

Policy Development

Almost all of the respondents expressed a deep desire for major changes in CAMH policy. Most felt strongly that the mental health reform needed to be fully implemented, and that mental health services had to be incorporated into the medical insurance system. It was believed that such a change would provide both impetus and resources to create better and more responsive CAMH services.

Most of the respondents claimed that there was insufficient policy development with regard to CAMH services, and that it would be extremely beneficial to have a senior CAMH

[9] http://www.mutav.org.il/

manager at the MOH. It was felt that currently children and adolescents did not have sufficient representation at the Ministry, which contributed significantly to the current stasis in clinical services. One important role for such an individual would be to work closely with the Ministries of Education and Social Affairs and Services to agree standards for provision of mental health services for children and adolescents, as well as clear procedural guidelines for working across the different service sectors. It was also felt that having a champion for children and adolescents would also help to direct resources and funds in the periphery within Israel.

Organizational Change

Connected to a desire for more policy development was the expressed desire of many of the respondents for more planning from central government ministries, especially for defining clearer pathways to care. Many of the individuals interviewed told us that the lack of collaborative working between education, health and welfare meant a lack of clarity about who should provide what services to children and families. It was suggested that there be a joint committee of health, education and welfare set up to define the goals of child mental health, decide who is best placed to provide interventions to achieve each of those goals, and to determine how these public sector agencies should work together.

Improved and Increased Training

There was general agreement that all health, education and social service professionals needed more and improved training in mental health, particularly in response to the high levels of mental health stigma that currently exist. In particular, pediatricians in the primary care system, social workers in the social service system, and teachers in the education system were highlighted as particularly needing more training in mental health.

There was also a call for greater interdisciplinary respect among professionals working in CAMH services (CAMHS), and in particular for professionals to know their limitations and understand what other professionals can provide.

Concern was expressed that CAMHS needed to be more culturally sensitive especially to the Arab, ultra-Orthodox and immigrant populations. There was also a call for more training and staff for specific population sectors including the Arab-speaking, dual-diagnosis, ultra-Orthodox sectors.

Enhanced Clinical Interventions

Many of the individuals whom we interviewed expressed a desire for more modern therapeutic techniques to be used with children and families, including CBT, family therapy approaches and greater use of parent training interventions. There was also a call for greater use of evidenced-based practice in CAMHS. Several of the mental health professionals we interviewed also felt that there needed to be a greater focus on early childhood. In addition, it was also suggested that there needed to be more multidisciplinary CAMH teams for complex cases such as eating disorders and childhood schizophrenia.

7. Summary

The purpose of this overview was to provide a general panoramic perspective of mental health services provided to children and adolescents in Israel. The emphasis of the interviews conducted was to examine the services provided in the health sector. However, we also met with individuals from the education and social service sectors to understand the range of services provided as well as their attitudes toward CAMHS in the health sector. We also talked to professionals working in the private and nonprofit sector. All of the individuals we interviewed felt that there was a need for systemic change and improvement of mental health services for children and adolescents.

The report is based on our findings at the time we conducted our interviews and certainly some things might have changed between that time and the date of publication.

7.1 Range of CAMH Services Available

A wide array of mental health services are already provided in Israel. These services can be viewed through the prism of the 4-tier CAMHS model developed in the UK:

Tier 1: Community-based services provided by professionals delivering universal services (i.e., not CAMH specialists):

- School counseling/School-based therapy initiatives
- After-school programs
- Mother and child clinics (Tipat Chalav)
- Prevention programs (e.g., parent training provided through kindergartens).

Tier 2: Community-based services provided by CAMH specialized services (usually only requiring one professional discipline):

- School psychology services
- Specialist after-school programs
- Specialist schools and kindergarten programs
- Specialist MOSAS community programs (e.g., child-parent centers)
- Community pediatric services
- Child development centers
- Individual clinical practitioners.

Tier 3: Services provided by multidisciplinary CAMH teams:

- Infant mental health services
- Child development centers
- Specialist programs operated by MOSAS (e.g., multipurpose daycare centers)
- Community CAMH clinics (operated by the MOH or Clalit)
- Hospital CAMH clinics
- Nonprofit centers.

Tier 4: Services for most serious cases usually requiring residential settings:

- Specialist MOSAS residential settings (including: therapeutic milieus, post-inpatient units, rehabilitation centers)
- Hospital inpatient wards
- Specialist hospital clinics (e.g., for eating problems, PTSD)
- Long-term care institutions.

As can be seen from the list above, there is a comprehensive range of frameworks that follow a natural progression dealing with the wide range of mental health difficulties seen in children and adolescents from simple to complex cases.

There are universal programs catering to all children in community settings, without requiring referrals to mental health specialists. One important example of this was the pilot project of the Ministry of Education aimed at providing parent-training programs to parents of kindergarten children. There are more targeted programs directed at children with specific mental health needs within tiers that include CAMH clinics and CDCs, as well as education and social services. Finally, there are specialist services for children with severe and complex needs, typically requiring cross-agency work (examples of these include inpatient hospital settings, which typically have health and education and welfare services all working closely together).

7.2 Major Themes and Challenges for CAMH Services in Israel

The major theme of the overview is the lack of an integrated service-delivery system for child and adolescent mental health. There are many innovative and cutting-edge programs, but there is no integrated system-wide framework for service provision, and this was the core theme that was repeated to us many times: the lack of a sustainable integrated CAMH system in Israel.

Out of this central problem emerge the major challenges for children, adolescents and families seeking mental health services. There is no national agency taking the lead in pediatric mental health policy development, in providing mental health training to child professionals, and in promoting mental wellbeing strategies for children and adolescents. There are insufficient numbers of mental health professionals working with children in the public sector, especially for specific population groups such as the ultra-Orthodox, and Israeli-Arabs. The lack of central planning also contributes to the lack of inter-organizational relationships across the public sector agencies, and poor working relationships between the different service sectors.

It was widely believed, albeit not by all those who were interviewed in the study, that it was necessary for the mental health reform to be passed so that the health plans be given responsibility for mental health. Until this happens, many respondents felt that there would always be limited resources for developing CAMH services within the health sector. It was hoped that the mental health reform would enhance funding and promote better integrated working within the health sector. The current status quo of CAMH services has led

to a situation in which vacant positions are being cut and clinical staffs are overworked and have limited capacity for outreach to other agencies, and to a lack of policy development guidance on how CAMHS should work with other service providers.

The obvious comparison that can be made with regard to service development is with the rise of the child development centers in the last 10-15 years. Under the leadership of the MOH, additional funding was secured through the Knesset, which meant that CDCs were included in the basket of health services provided in Israel. This has given both the MOH and the health plans the impetus to develop nation-wide services that are multidisciplinary in nature; work across social service, education and health sectors; and guided through centrally (i.e., the MOH) agreed principles of assessment and intervention. According to many of the individuals we interviewed who work in CDCs, Israel now offers one of the best services in the world for young children and their families. In this way, the development of CDCs is potentially an excellent model for how CAMH services might be developed across Israel.

The concomitant effect of the rise of the CDCs has also been the development of wider awareness of early childhood developmental problems among education, social service and health professionals. Having a place to which children with developmental problems can be referred reduces stigma and increases awareness, especially for children with problems like autism and mental retardation. Ensuring cooperation and continuity among different CAMH services could also reduce the stigma of mental health in children and adolescents, and increase opportunities for educating all professionals working with children about mental health. These issues were important themes expressed by many of the individuals interviewed for this report.

One further core theme expressed by the respondents was a desire for more modern therapeutic techniques to be used with children and families including: CBT, family therapy approaches and greater use of parent training interventions. There was also a call for greater use of evidenced-based practice in CAMH services. An integrated CAMH system, with central government directed guidelines lends itself naturally to determining and implementing greater use of evidenced-based approaches.

7.3 Areas for Further Study

The main task of this overview was to provide a broad overview on child and adolescent mental health services. A useful next step might entail conducting a fuller mapping of services that could include a system-wide survey across health, education and social service sectors to investigate more clearly who the recipients of services are and the range of services provided. It could also be possible to look at lengths of waiting times for both assessment and treatments, as well as the typical lengths of treatments. This fuller mapping could provide a clearer analysis of strengths and challenges in the system, and help direct policy development. This kind of CAMHS mapping is done on an annual basis in the UK, and

provides important information for directing policy and funding.[10] It will be particularly important to carry out such a mapping during the current three-year transition period for Israel's mental health insurance reform (2012-2014).

In the longer term, further replication on a regular basis of the work of Mansbach-Kleinfeld (2009) and the ISHEMA study would be a valuable method of accurately gauging levels of need and services provided. The first study indicated that 11.7% of adolescents in Israel have a mental health problem. In addition, they found that only a minority of families sought professional support, indicating the levels of need were far higher that the levels of services provided. This work of Mansback-Kleinfeld and her colleagues should be updated and extended to examine this issue more precisely and to provide focus for where service capacity is particularly limited and in need of development.

[10]See the following website for up-to-date information about how this process is conducted, and the results of the survey at www.childrensmapping.org.uk

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Appendix I - Examples of Points of Contact between the Social Service and Mental Health Systems

Except for a few post-inpatient and therapeutic residential units, social services were described to us as not providing direct mental health services. The social services make a distinction between children with mental illness who are required to be seen within the health system, and those with emotional and behavioral problems but without mental illness. The distinction is based on the level of severity, and whether psychiatric input is required. A wide array of social services provides mental health support and interventions to the latter group of children, including:

- Residential units
- Child-parent centers
- Specialist childcare centers
- Specialist after-school programs.

These services are related to the current survey because there are potentially important points of contact with the mental health service system. We consider each of these in turn.

Residential Units

The Ministry of Social Affairs and Services provides residential care to more than 6,200 children in Israel in a range of settings that include:

- Specialist educational settings
- Specialist therapeutic milieus
- Post-inpatient units for children and adolescents leaving hospital inpatient wards
- Residential care units for children placed out of home but who cannot be adopted or fostered
- Rehabilitation centers.

Children and adolescents are referred into these residential placements by social workers, and typically with the agreement of a local planning and assessment committee comprising professionals from the social, education and health services. Only the most severe cases are referred to residential care, and typically include children requiring protection from abuse or neglect, children with major behavioral or emotional problems, and children with a variety of learning disabilities. It was reported to us that there has been a significant increase in the number of children needing residential placement in the last five years (source: Dalia Lev Sadeh, personal communication).

These residential units are managed and staffed mainly by social workers, although educational workers, psychologists and a variety of expressive arts therapists also provide a range of therapeutic services. The most common emotional and behavioral problems seen in these settings include: ADHD, anxiety, depression, self-harm and suicidal thinking (source: Dalia Lev Sadeh, personal communication). There are also children who have eating

problems, psychosis and borderline personality disorder. When mental health input is needed, especially psychiatry, the residential services purchase time, either from the health plans or from the private sector.

Child-Parent Centers

Child-parent centers are a community-based service of the social services that are managed by either local social service departments or nonprofit organizations. They target children aged 5-12 years who have severe behavioral and/or emotional problems that stem from poor relationships between them and their parents. Referrals into the child-parent centers come from social workers, who typically, have already had extensive experience working with the families, and are able to judge if they are motivated to change and use the resources of the centers to change the family dynamic. The range of emotional problems seen in the children include: Anxiety, depression, anti-social behavior, learning problems and ADHD. A significant proportion of families referred to the child-parent centers are under the supervision of the child-protection system with the aim of improving parenting practices and child-parent relationships to reduce the risk of abuse to the child.

The emphasis is on offering the family a range of expressive art therapies and some discussion with therapists about the issues affecting the child-parent relationship. There is a mix of individual child and parent sessions, as well as joint family sessions depending on the needs of each family. There is also group work in the centers, again with an emphasis on expressive art therapy, play therapy, and animal-assisted therapy. Most families attend the centers once a week and most interventions last 12 months or longer. In addition to their attendance, families continue to receive support from their social worker at the local social service departments.

Specialist Daycare Centers

Israel has well-established daycare centers for children aged 0-3 years, and MOSAS has built into this system a network of 20 "multipurpose daycare centers" for children with additional cognitive, language, emotional and social needs. In addition to ensuring the children's safety and physical care, the service's goals are to promote the children's development and to screen for developmental or medical problems. In addition, parents are given support and guidance within these specialist daycare centers so that they are better able to meet their child's needs and improve parenting skills and family relationships. The specialist daycare centers are operated by either MOSAS or nonprofit organizations in the local community.

In addition to the normal 8-hour day, these centers operate programs until 7 p.m., which older children aged 3-6 years can attend with their families.

These centers are typically managed by a social worker, and are staffed by social workers and expressive art therapists. Interventions include music and art therapies, parenting counseling and group activities. Children and families are referred to these specialist daycare centers through the local social services, and often via the child protection officer

who seeks to prevent the child from being taken out of the family. The interventions typically last for at least 12 months.

Specialist After-School Programs

MOSAS funds more than 1,000 after-school frameworks throughout Israel, most of them aimed at children considered to be at risk or from vulnerable populations. Sixteen of these programs are specifically designed for children with emotional problems and/or behavioral problems. There are some 12 children per program/framework, each of which takes place from 1-7 p.m. These programs are designed for children aged 5 to 18 years, with groups of children within in a three-year age range. The after-school programs take place in different community-based locations including community centers and childcare centers.

The main goal of these programs is to provide support to the child and his/her family and to prevent further deterioration that could potentially lead to the child being placed in a residential setting. The programs are designed to expose children to positive experiences where they are able to rebuild self-esteem and self-confidence. The after-school programs offer a structured framework within which a variety of professionals provide psychosocial interventions to meet each individual child's needs. This may include animal, art, drama and music therapies. It may include social workers and/or psychologists providing individual counseling as well as family counseling sessions. There are often consultations provided to parents and schools. These programs are also intended to provide immediate response and assistance to any crisis situation that may arise.

The typical length of treatment is three years for a child and his/her family. Referrals are arranged through local social services, often through the child protection services, and there can be long waiting times for entering the program.

Appendix II: Examples of Nonprofit Organizations Involved in Addressing Children's Mental Health and Emotional Needs

In this appendix, we briefly provide information on three nonprofit organizations, as examples of how such organizations are involved in a variety of ways in addressing children's mental health and emotional needs. The organizations described are:

- Beit Issie Shapiro,[11] which offers numerous programs for children with learning disabilities and intellectual impairment
- Telem,[12] which offers diagnostic and therapeutic services for children and adults with mental illness
- The Israel Association for Child Protection – Eli,[13] which offers a wide array of programs for children who have experienced or are currently experiencing abuse

Beit Issie Shapiro provides services in the center of Israel to over 7,000 individuals every year through therapeutic childcare centers, after-school programs and health clinics (including mental health) across all Jewish and Arab communities. Many of the programs receive funding from government agencies (e.g., education for the childcare centers; social services for the after-school programs) and the health plans (e.g., for the health clinics). However, such sources of funding cover only 28% of the budget with the remaining funded by donations (50%) and parents (22%). The organization provides a mental health service, working closely with the child and adolescent psychiatry department at Schneider Hospital, to children and families with a dual diagnosis of learning disabilities (including intellectual impairment) and mental illness. Most referrals come from the families themselves, or schools, and initial appointments are offered within a month. A range of interventions are provided including psychopharmacology, speech therapy and communication skills development, occupational therapy, and family therapy. The main psychotherapy approach used is cognitive behavioral therapy.

Telem provides a wide range of mental health services for children and adults in 11 clinics throughout Israel from Beersheva in the south to Haifa in the north. It has also been contracted by the Ministry of Education to provide counseling services in a large number of vocational schools. It also operates a number of child development clinics that are integrated into its mental health services. Most of its funding comes from private clients and government contracts. Approximately 50% of the 1,000 new patients every year are children and adolescents, who are able to receive a range of therapeutic interventions including psychiatry, cognitive behavioral therapy, family therapy, and psychodynamic approaches.

Eli provides a hotline service to both children and professionals wishing to report abuse as well as comprehensive clinical services around the country. It offers individual, family-based

[11] www.beitissie.org.il
[12] www.telem.org.il (Hebrew only)
[13] www.eli.org.il

and group therapy, using both CBT and psychodynamic approaches. It often uses systemic approaches and works closely with the school and social services. Eli also has access to psychiatrists who provide psychopharmacological interventions when necessary. In 2009, more than 3,000 individuals received therapeutic support through Eli. Much of its funding is from philanthropic donations. Officially, it charges a fee, but families pay according to their ability and most referrals come from the families themselves. It typically sees all patients within one week. Eli receives some referrals from local social service departments, family courts service and even from prison organizations, which pay for the services received. Thus, a significant number of children with behavioral/emotional problems might be seen outside of the public system, or with unnecessary duplication of services.