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The Israeli Law for the Rehabilitation in the Community of Persons With Psychiatric Disabilities: Achievements and Challenges

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Objective: The Community Rehabilitation of Persons with Mental Health Disability Law (2000a) is one of Israel's most important pieces of social legislation. It grants persons with psychiatric disabilities the right to receive rehabilitation in the community. This article is a case study of the development and implementation of a policy that led to the Rehabilitation Reform and that has become an important component in Israel's comprehensive mental health reform. The purpose of the study was to review and analyze the law and its elements, examine its implementation during its first two decades of operation, and to identify the issues it faces entering its third decade of application. ***Method:*** The study examined the key components of the reform such as intended beneficiaries, financing, workforce, and services provided. It used Israel's official statistical data and drew upon a series of interviews with officials and experts on rehabilitation, mental health and social services. ***Results:*** In 2020, 30,000 persons were receiving community psychiatric rehabilitation services, constituting about one fifth of the estimated eligible population. In addition to the reform's achievements, this article also identifies a number of issues. Toward the end of the second decade, problems between the psychiatric Rehabilitation Unit and the mental health services became apparent. ***Conclusions and Implications for Practice:*** As the Rehabilitation Law enters its third decade, it is recommended to establish an independent committee of experts to examine needed modifications in light of the conclusions drawn about the first two decades of its implementation.

Impact and Implications
This article presents a case study of policy change, effected by an Israeli law guaranteeing persons with serious psychiatric disabilities eligibility for community psychiatric rehabilitation services. Analysis of the reform's first two decades showed great achievements, however, indicated that the services do not yet cover the entire intended beneficiaries population, and revealed frictions with the mental health establishment. The article concludes with recommendations for the third decade of the Rehabilitation Reform.

Keywords: community psychiatric rehabilitation, social legislation, Israel

The Community Rehabilitation of Persons with Mental Health Disability Law (hereinafter: The Rehabilitation Law) is one of the most important pieces of social legislation enacted in Israel (Aviram et al., 2012; Community Rehabilitation of Persons with Mental Health Disability Law, 2000a)[1] and one of the most advanced examples of mental health legislation in the world (Drake et al., 2011).

This article presents a case study of policy change effected by a law guaranteeing persons with serious and persistent psychiatric disabilities eligibility for a basket of community psychiatric

[1] The English translation of the Law are available at https://www.ispraisrael.org.il/action?LanguageID=2&Languagecode=en&type=search&query=law.

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rehabilitation services. The implementation of the Rehabilitation Law that began in Israel in 2001 led to substantial changes in the living conditions of those using the new services, and this reform became an important and even essential component of Israel's ensuing broad reform in the mental health services system (Aviram, 2012; Aviram & Azary-Viesel, 2018a, 2018b; Elitzur et al., 2004; Haver et al., 2005). This important restructuring, implemented in 2015, marked the culmination of the state's nearly four decades of efforts to shift the locus of treatment of persons with mental illnesses from a primarily psychiatric hospital-based system to community systems (Aviram, 2019; Aviram et al., 2007; Israel's State Comptroller, 2002, 2007, 2010, 2016).

The Rehabilitation Law, along with the ensuing "Rehabilitation Reform," represents much more than an alternative to long-term psychiatric hospitalization. Drawing on innovative methods for community psychiatric rehabilitation of persons with serious and persistent psychiatric disabilities[2] and their integration within society, it reflects a conceptual change in public attitudes to persons contending with disability due to mental illness in terms of society's commitment to them, and the methods of helping them recover and integrate into the community (Shershevsky, 2006, 2015, 2022). To put this into practice, the law mandated allocating a dedicated budget for this purpose.

The law and subsequent Rehabilitation Reform created an opportunity to formulate new policies, develop previously unknown knowledge, and implement practices geared to the rehabilitation of persons with psychiatric disabilities, including working in close cooperation with those persons and their family members. All of this was greatly assisted by new voices based on life experiences of persons with mental health issues such as Chamberlin (1979), Deegan (1988), Leete (1989) and others, as well as the work of scholars like Bill Anthony (1993) and his team from Boston University, alongside others (Davidson et al., 2010; Slade, 2009b; Strauss, 1986), in developing person-centered therapy and recovery-oriented methods.

The community psychiatric rehabilitation system that evolved over the first two decades of the Rehabilitation Law's implementation can boast extremely impressive achievements. However, toward the end of the second decade, dark clouds began hovering over the Rehabilitation Unit[3] due to difficulties arising from systemic-organizational problems and responses of its "functional environment" (Aldrich, 2008; Emery & Trist, 1965; Pfeffer & Salancik, 2003; Thompson, 1967) to this new organization which had become part of the mental health services and had to find its place within the mental health system.

The purpose of this article is to examine the achievements of the Rehabilitation Unit in the two decades of its existence while analyzing the problems impeding its continued proper functioning. The discussion of this specific reform in the mental health services will also serve as a platform for examining its effects and implications on the other mental health services and social services, as well as for discussing the type of issues facing social reforms in general. We argue that reforms do not simply end with the enactment of a law or a decision about policy change—this is simply the beginning. Rather, a true policy change is ongoing and dynamic and achieved by implementing decisions within a specific context.

Following a brief description of the law's key points, unique nature, and importance, we will then discuss the process, circumstances and conditions leading to the law's enactment; continuing with a presentation of the main trends which occurred during the first two decades within the law's main sphere of activity (Aldrich, 2008; Aviram, 1979a, 1979b; Emery & Trist, 1965; Pfeffer & Salancik, 2003; Thompson, 1967); and concluding by addressing the challenges facing the Rehabilitation Unit and its affiliated services, as well as our recommendations regarding these issues.

Method

We gathered and analyzed statistical data, mainly from Israel's Ministry of Health, the Central Bureau of Statistics, and the National Insurance Institute. We also conducted a review of the literature on the law and its implementation and on Israel's mental health services since the law's implementation. In addition, we held a series of personal interviews with policy makers, service directors, service providers, and nonprofit organizations led by persons with psychiatric disabilities—the consumers of these services, as well as by their family members.

The Community Rehabilitation of Persons With Mental Health Disability Law

The purpose of the law is:

> To strive for and advance the rehabilitation and integration of the mentally disabled in the community in order to allow them to achieve the maximum degree of functional independence and the highest possible quality of life, while preserving their dignity in the spirit of the Basic Law: Human Dignity and Liberty. (Community Rehabilitation of Persons with Mental Health Disability Law [English version], 2000b, p. 1)

The law is based on two fundamental principles:

1. A person coping with a psychiatric disability has a basic right to rehabilitation.
2. The basket of rehabilitation services allocated to persons with psychiatric disabilities should be based on a professional decision.

The law explicitly provides a detailed account of the rehabilitation basket of services from which a professional committee can allocate services to a person in need of rehabilitation.[4] This basket includes employment, housing, education, social activity, dental treatment, and assistance for the family members of persons with psychiatric disabilities.

Application of the law involves providing from the basket of services based on an individually tailored rehabilitation plan designed to place the persons and their desires at the center of the process. Moreover, the law mandates that the rehabilitation budgeting be dedicated entirely to community-based rehabilitation.

[2] The law uses the term "mentally disabled" as this preceded the terminology change which occurred in later years (Granello & Gorby, 2021; United Nations, 2006).

[3] While the Rehabilitation Department is the formal title, it drew objections from the professional staff, that believed this should be an independent division rather than a department subordinate to the Mental Health Division. Due to these disagreements, the term "Rehabilitation Unit" is used throughout the article.

[4] According to (former) MK Tamar Gozansky, who initiated the law, inclusion of the rehabilitation basket of services as an integral part of the law was intended to enable its immediate implementation following its enactment (Personal interview, October 16, 2021).

The law clearly defines the eligible population: A person above the age of 18 years who has been examined by a psychiatrist or anyone qualified to determine the disability level for the payment of National Insurance Institute benefits and for whom a level of at least 40% disability has been determined due to a mental health disorder in accordance with the standards of the National Insurance Institute regulations is eligible to apply for a rehabilitation basket of services.

The allocation of services to individuals is determined by a professional committee and its receipt does not depend on the budget but is an individual right like any other allowances granted by the National Insurance Institute.

In addition, the law prescribes that the Minister of Health must appoint a national council tasked with advising the minister on policy matters and on community psychiatric rehabilitation services, initiating research and more. Council members include representatives from: government ministries; pertinent professions; local government; the academic world; and organizations led by persons with psychiatric disabilities and by their families.

From Vision to Reality: The Process of Enactment of the Community Rehabilitation of Persons With Mental Health Disability Law

The process leading to the enactment of the Rehabilitation Law can teach us important lessons about what is required for legislation focusing on weaker and marginalized groups within the population.

The initial attempts at community psychiatric rehabilitation programs began already in the 1960s, but these were few and far between and were implemented mainly within hospitals (Aviram, 2007; Aviram et al., 2006; Shershevsky, 2015). Although the (National Health Insurance Law [order no. 2, 2012], 1994) included mental health services, it postponed transferring responsibility for the mental health services from the government to community health organizations, as the law prescribed. In view of the failed attempt to implement a mental health reform in 1995 (Aviram, 2007, 2019; Dvir & Shamir, 2017), the authorities understood that psychiatric disabilities, primarily the serious and persistent ones, require special attention, and that adopting appropriate methods of contending with them might facilitate an overall mental health reform (Aviram, 2010).

Concomitantly, the Knesset (Israeli parliament) undertook an independent effort to enact legislation. Leading this effort was the then Member of Knesset (MK), Tamar Gozansky. Although she was a member of a small political party, she had gained considerable respect from her colleagues as a leading social legislator. She established a broad coalition of MKs, professionals, and citizens, including persons with psychiatric disabilities and family members (Dvir & Shamir, 2017; Perez-Vaisvidovsky & Aviram, 2019).

Originally, some authorities, such as the Ministry of Finance, the Ministry of Health and its Mental Health Division as well as members of the psychiatric profession, had reservations about the law, which was not under their full control. However, once they understood that this separate legislation would promote the broader health reform, and that it had a good chance of getting enacted, they decided to join Gozansky's initiative, thereby gaining the opportunity to affect the nature of the legislation (Perez-Vaisvidovsky & Aviram, 2019; Shershevsky, 2006, 2015).

Of course, we should not ignore the impact of new global trends in the field of mental health starting from the mid-twentieth century, first with the deinstitutionalization processes taking place in the United States and Europe (Goodwin, 1997; Mechanic & Rochefort, 1990; Szasz, 1960, 1974), and later involving community treatment and innovative rehabilitation methods for persons with psychiatric disabilities (Anthony, 1992; Corrigan et al., 2008; Knapp et al., 2007; Lachman, 1998; Slade, 2009a, 2009b; Thornicroft & Tansella, 2009).

We should note that when the Israeli law was first implemented, community psychiatric rehabilitation was in its infancy in Israel. Fortunately, the exposure to community psychiatric rehabilitation approaches promoted by scholars such as Anthony (1992), Basaglia et al. (1987), Corrigan et al. (2008), Davidson (2003), Roe et al. (2022), Slade (2009b), Solomon, and Thornicroft (Thornicroft & Tansella, 2009) prompted an important learning process aimed at establishing recovery-oriented rehabilitation practices.

Moreover, Israel's professional community adopted the fundamentals of the emerging recovery approach that was becoming accepted globally both by leading professionals and by those with psychiatric disabilities (Amering & Schmolke, 2009; Anthony, 1993; Davidson et al., 2010; Roe et al., 2009), emphasizing the importance of readiness for rehabilitation, personal goals, individual plans, and measurement of outcomes

These principles became the foundations of the practice of rehabilitation in Israel. However, this approach met with considerable opposition from some of the mental health treatment professions, making it necessary to make basic changes. At the outset, the recovery-oriented approach differed radically from the then existing knowledge regarding the ability of persons with psychiatric disabilities to experience change (Lachman, 2007). An additional challenge involved the attempts of the authorities to exploit the recovery-oriented approach in order to move people from one service to another without properly checking their ability to exercise choice and self-determination, the focal point of the approach (Anthony, 1993; Anthony & Farkas, 2009, 2012; Anthony & Liberman, 1986).

The Intended Beneficiaries

The intended beneficiaries include persons with serious and persistent psychiatric disorders and with extreme medical and functional disability. These disorders are ranked relatively high in the Global Burden of Disease (Chernichovsky & Bowers, 2014; Murray & Lopez, 1996; Whiteford et al., 2013). This population often suffers from poverty, stigma, and social exclusion.

According to National Insurance Institute data, in 2005, at the time of the law's initial implementation, there were 52,304 recipients of the general disability allowance who had psychiatric disabilities[5] at a level of 40% or higher, as mandated by the Rehabilitation Law. This number grew considerably, by 83% during the next 15 years, and reached 95,691 persons in 2020 (Research and Planning Department, National Insurance Institute, personal communication, February 21, 2022).[6]

[5] Items 33 and 34 alone.

[6] We should mention that eligibility to a general disability allowance is based on the loss of work ability, in addition to the disability itself (The National Insurance Law, 1995).

The question is whether this identified population actually constitutes the entire eligible population, to which the answer is no. Under the law, an individual must apply to have their eligibility evaluated, but not everybody who might be eligible indeed applies, as many refrain from applying for various reasons, such as family objections or fear of stigma. Moreover, many of those who belong to the disabled and poor populations are entirely unaware of their rights (Gal et al., 2009).

Based on the above and drawing on studies conducted on persons in Israel with serious and persistent psychiatric disabilities (Aviram et al., 1998; Aviram & Rosen, 2002), the extent of the intended beneficiaries at the start of the implementation of the law (2001) can be conservatively estimated at between 85,000 and 100,000 people. Considering a 46% increase in Israel's population between 2000 and 2020, the intended beneficiaries of the Rehabilitation Law can be estimated to number 150,000 individuals, a ratio of 24 per 1,000 people in the population within the relevant age bracket (18+)[7] (Central Bureau of Statistics, 2021a).

If we add to this the close family members of these individuals, who to a large extent bear the onus of care, then we reach about 350,000–400,000 people (as of 2020) constituting the intended beneficiaries on the primary and secondary levels of the community psychiatric rehabilitation system; a ratio of 57–65 per 1,000 people at the age of 18+ within the general population (Central Bureau of Statistics, 2021a).

It should be noted that in Israel, the largest group of recipients of a general disability allowance are persons whose main reason for receiving it is a psychiatric disorder, and the proportion of this group within the population of disability allowance recipients has been on the increase (National Insurance Institute, 2001; Research and Planning Department, National Insurance Institute, personal communication, February 21, 2022).

The Economic and Social Cost of Mental Illness

Studies have referred to the significant financial cost of mental illnesses (Global Mental Health Action Network, 2021; Kadakia et al., 2022; Kessler et al., 2008; Rosenthal, 2022; The Sainsbury Centre for Mental Health, 2003; Whiteford et al., 2013), that is far higher than the government budget set aside for mental health services (Mechanic et al., 2014). Although the inherent financial and social benefits of adopting an appropriate approach to dealing with mental illnesses have been highlighted and recommended (Zweifel, 2018, 2020), unfortunately, studies on this topic have not been conducted in Israel so far and the matter should be researched in depth.

However, adjusting for the size of the population and the standard of living in Israel (according to per capita gross domestic product [GDP]), the total annual cost of mental illnesses to Israeli society reached USD 13 billion in the early 2000s (Aviram, 2017). Adjusted to 2020, considering only the population growth, this cost would have reached about 20 billion today (Central Bureau of Statistics, 2021a).

Moreover, drawing on the results of the study conducted by Kessler et al. (2008) in the United States (adjusting for the per capita GDP and size of the population in Israel), the annual loss in GDP attributable only to the nonemployment of persons with psychiatric disabilities in Israel was estimated at USD 3 billion for the year in which Kessler et al. (2008) conducted their study in the United States, a number that is likely to grow due to the population as well as GDP growth (Aviram, 2017).

Implementation of the Rehabilitation Law in the First Two Decades Since Its Enactment

The process of implementing the law was rapid. Already in the first decade of its operation, it enjoyed impressive achievements (Aviram, 2017, 2019; Drake et al., 2011), and these successes continued into the second decade of its application. During these two decades of the Rehabilitation Reform, the number of persons who received community psychiatric rehabilitation services increased almost fivefold. While in 2001 only 7,512 persons received services, this number rose rapidly, increasing by 150% during the first decade, and by 65% during the second, reaching 30,988 persons in 2020 (Division of Mental Health, 2008; Ministry of Health, personal communication, March 13, 2022). Nevertheless, even assuming that only half the intended beneficiaries would be interested in receiving rehabilitation services, this would still involve a total of 75,000 people, meaning that according to the 2020 statistics, only about 40% of the intended beneficiaries actually receive the services (Division of Mental Health, 2022).

The introduction of the rehabilitation services in the last 20 years has led to many important results in the effort to enable persons with serious and persistent psychiatric disabilities to continue their lives in the community and to enable them to have a sense of belonging and be active in their daily lives. The establishment of the rehabilitation services allowed thousands of individuals to relocate from hospital beds to locations within the community. Already by the end of the first decade of the Rehabilitation Unit's activity, after the initial generation of those institutionalized in hospitals had already transferred to the community psychiatric rehabilitation system (mainly in community-supported living arrangements), changes occurred in the population in need of rehabilitation. While at the beginning of this period, almost half of those applying to the rehabilitation system were referred from the psychiatric departments in general hospitals and from (government and private) psychiatric hospitals, over the course of time, this number declined sharply, and in 2020, it was only 19%. Concomitantly, the percentage of those referred from the ambulatory services reached 81% in 2020 (Ministry of Health, personal communication, March 13, 2022), a number that could also have been affected by the Insurance Reform that came into effect in 2015 (National Health Insurance Law [Order No. 2], 1994).

Examining the state of the inpatient system in the years since the law's implementation reveals noticeable changes. The number of psychiatric beds and inpatient days in Israel decreased significantly during the period of the reform, as well as the number of persons hospitalized (see Table 1). It is reasonable to assume that these data indicate the Rehabilitation Reform's significant impact on the mental health services; it is also noteworthy that an Israeli study has found that community psychiatric rehabilitation was associated with a higher probability of staying in the community and shorter inpatient episodes (Lerner et al., 2012).

[7] The calculation was made in relation to the general population in the 18+ age bracket—the relevant age group for eligibility for the Rehabilitation Law.

Table 1
Psychiatric Beds, Inpatient Days, and Persons Hospitalized

Year	Psychiatric hospital beds[a]	Psychiatric inpatient days	Persons hospitalized[a,c]
2001	5,500 (0.85)[b]	1,722,537 (374)	5,256 (0.8)
2010	3,451 (0.45)	1,207,844 (158.4)	3,525 (0.5)
2019	3,542 (0.39)	1,219,601 (134.7)	3,077 (0.3)

Note. Department of Spokesperson, Communication and Information, Central Bureau of Statistics, personal communication, January 2, 2022; Division of Mental Health (2008, 2019, 2021).
[a] At the end of the year. [b] Brackets refer to number per 1,000 population. [c] Data of 2000, 2010, 2020.

Although the significance of these changes should not be underestimated, analysis of the data reveals some disturbing results. In contrast to other countries that have implemented mental health reforms (Goodwin, 1997; Mechanic & Rochefort, 1990), in Israel, not even one government hospital for the mentally ill was closed. Furthermore, the main decrease in the number of psychiatric beds in Israel was due to the reduction in the number of private hospital beds (Aviram, 2012). Moreover, the hospitals' inpatient budget had not been reduced despite this reduction and was criticized for being overly high in comparison to the ambulatory and rehabilitation budgets (Israel's State Comptroller, 2007, 2010).

The Intended Beneficiaries

Examining the nature of the population reaching the community psychiatric rehabilitation system since the Rehabilitation Law was first implemented reveals several significant changes. A need for the rehabilitation of persons with psychiatric disabilities who were already residing in the community at the beginning of the law's implementation, or for those with dual morbidities, became apparent. The proportion of those who were referred to the rehabilitation services without any hospitalization history accounted for 27% in 2020, compared to 18% in 2001; and the percent of those who were referred by the ambulatory services without any previous hospitalization have increased considerably from a low 12.8% at the beginning of the period to 48.7% by 2020 (Ministry of Health, personal communication, March 13, 2022). Amongst the population referred from the inpatient system, the proportion of those with an hospitalization history of 1 year and more have increased as well, from 35% in 2001 to 89% in 2020 (Ministry of Health, personal communication, March 13, 2022).

Furthermore, the number of 18–24 year olds undergoing rehabilitation increased by 76% percent between 2009 and 2011 (Division of Mental Health, 2012, 2021). An increase also occurred in the size of the elderly population (65+) among those undergoing rehabilitation, a change which we may assume is connected to the aging of the overall population (Central Bureau of Statistics, 2021c) and possibly also the improved utilization of rights among this age group.[8] We should point out that the proportion of elderly among the total number of rehabilitation service users is still lower than the proportion of elderly persons among the 18+ age group within the overall population (Central Bureau of Statistics, 2002, 2021b).

Some population sectors and age groups are still in need of specially tailored services, such as the Arab population (Haj-Yahia et al., 2019; Israel's State Comptroller, 2010), the elderly service users (Kaplan et al., 2019; Lurie & Fleischman, 2019; Roe et al., 2019), and persons with psychiatric disabilities combined with other medical and complex disabilities, who need support from the rehabilitative services as well as from ambulatory clinics and from other social welfare organizations (See Welfare Services for Persons with Disabilities Law, 2022).

The 200,000–250,000[9] family members caring for those with psychiatric disabilities must also be added to the intended beneficiaries for the community psychiatric rehabilitation services. Although this topic is presented as a key change within the system, there is no data on the support provided to the families and its extent. Nevertheless, as opposed to some welfare states (see Care Act, 2014), in Israel, this issue has not received sufficient attention, not to mention appropriate legislation.

Budgets

The Rehabilitation Unit's expanded activity was reflected in an increase in the budget designated for it (see Table 2). By 2017, the budget had already accounted for 25% of the overall government budget for the mental health services (Accountant General's Division, 2017) and in 2020, amounted to about NIS 1.25 billion[10] (Accountant General's Division, 2020). It is important to note that 20 years ago, the government budget for these services was almost nonexistent (Accountant General's Division, 2001).

However, these changes might be somewhat misleading, as this increase does not necessarily mean that the funds allocated for the community psychiatric rehabilitation system correspond in practice with the system's needs. Moreover, while in the original planning, the legislature believed that budgets for rehabilitation would also increase by pooling budgets from other authorities, in practice, today, the authorities sometimes refer those in need of services that were previously funded from their budgets to the rehabilitation system (Mazlawi, 2020; The Special Committee for Welfare and Labor Matters, 2020).

We should also point out that the calculation (see Figure 1) refers to actual budgets. Therefore, it does not reflect the budgetary steps taken by the system to deal with its potential growth (Israel's State Comptroller, 2007, 2016).[11]

As may be recalled, most of the rehabilitation services are operated by private providers. One common claim is that one of the reasons for the decline in the quality of the rehabilitation services is the nonrealistic pricing in the tenders for the rehabilitation services (David, 2020; District Court of Haifa, 2022; The Health Committee, 2022; Zuk et al., 2022). Moreover, in some cases, the pricing was even lower than the norm for parallel state-run programs,

[8] Over the years, there has been a marked increase in the proportion of service users aged 65+ of the total population receiving services. In late 2001, this population accounted for only 3.23% of those undergoing rehabilitation, and by late 2020, had reached 8.40% (Ministry of Health, personal communication, March 13, 2022).
[9] As of 2020, this number represented a ratio of 32–40 per 1,000 people at the relevant population of 18+ (Central Bureau of Statistics, 2021b).
[10] USD 357,336,046 (Bank of Israel, n.d.). The cost per 1,000 people in the relevant age group (18+) was USD 57,768.
[11] The rate of population growth in Israel is relatively large in relation to the other Organization for Economic Co-operation and Development countries. In the 20 years since 2000, the population in Israel has grown by 47%. In 2020, the 18+ age group constituted about 70% of the total population (Central Bureau of Statistics, 2021a).

Table 2
Public Expenditure on the Community Rehabilitation of Persons With Psychiatric Disabilities, 2001–2020

Year	Original expenditure[a]	Regulated expenditure[b]
2001	12,897	20,594
2005	21,273	34,402
2010	24,691	33,475
2015	31,467	35,051
2020	39,668	39,668

[a] The data are from the Accountant General's Division (2001, 2005, 2010, 2015, 2020) and personal communication (Accounting, Ministry of Health, March 22, 2022). [b] The extent of the expenditure each year was adjusted to the 2020 price level based on the median wage of salaried employees for a working month (National Insurance Institute, 2003, 2007, 2012, 2017). Due to the lack of data, an estimate was made of the median wage in 2020. The median wage of salaried employees in the relevant years (the rates of change appear in parentheses): 2001—4,685 (-); 2005—4,626 (−1.3%); 2010—5,518 (19.3%); 2015—6,716 (21.7%); 2020—7,481 (11.4%).

and so were the usual payments for the staff (District Court of Jerusalem, 2017).

Workforce

The workforce operating the services is a vital element in determining service quality and even the extent of the law's implementation, but despite its importance, data concerning it is not regularly published. Nonetheless, Israel's State Comptroller (2007, 2010, 2016) stated that the workforce running the services, operating the rehabilitation committees, dealing with supervision and oversight, and managing the cases was far from adequate.

Moreover, there are no clear definitions of the specific background and training necessary for employment in the community psychiatric rehabilitation field, neither for professional workers nor for not professional ones (Roe et al., 2011). Furthermore, no suitable promotion track for community psychiatric rehabilitation has yet been devised. As the professional workforce comes from various professional disciplines (mainly occupational therapy and social work), the promotion tracks in these professions do not properly reflect the field of psychiatric rehabilitation in the community.

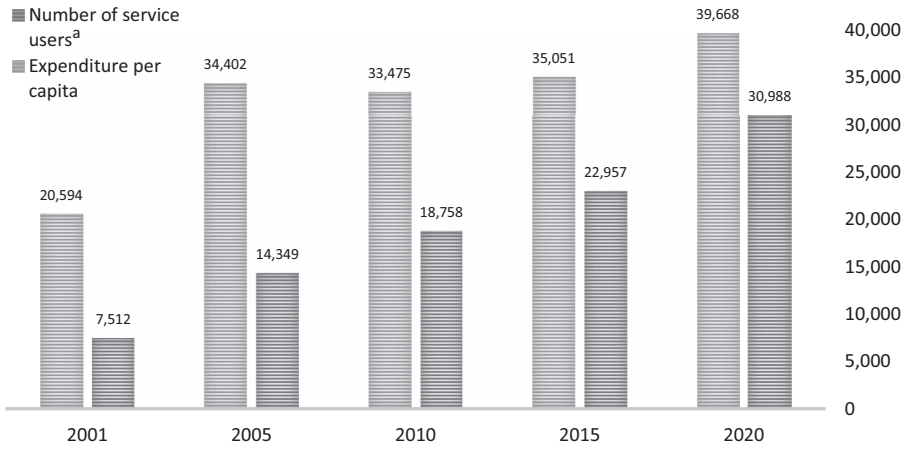
Services

During the last decade, there has been a noticeable improvement in the scope of activity and the efficiency of the rehabilitation and monitoring committees, and the level of use of the rehabilitation basket of services allocations. The number of applications to the first rehabilitation committees increased substantially: Between 2010 and 2020, it rose by almost 50%. In the last 5 years, there has been an additional significant increase in the number of applications, which stood at 37% in 2020 (Ministry of Health, personal communication, March 13, 2022). This could be a result of the Insurance Reform coming into effect in 2015 (National Health Insurance Law [Order No. 2], 1994) apparently leading to numerous applications from the ambulatory services.

There was also a concomitant increase in the rate of use of the allocated services during the first 6 months following the committee's allocation decision, from 66% at the start of the decade to 80% at its end. The changes identified in the two largest areas of services offered by the community psychiatric rehabilitation system, community-supported living and employment, were dramatic during the second decade of the Rehabilitation Unit's activity. The number of service users in supported housing almost doubled, reflecting a 96% increase, while in employment programs, a 69% increase occurred (Division of Mental Health, 2012, 2021). Despite these positive changes, a high proportion of the approved services are still not utilized, as the average rate of utilization of the overall services in 2010, 2015, and 2020 was only 40% (Ministry of Health, personal communication, March 13, 2022).

We should also point out that to our knowledge, the procedure for changing and updating the basket of services that was wisely

Figure 1
Public Expenditure on Community Rehabilitation of Persons With Mental Health Disability, 2001–2020



[a] The number of service users during the year. This number is 18% higher on average than the number of service users at the end of year.

included in the law have not been used yet, and the basket has not been appropriately evaluated. Furthermore, the community psychiatric rehabilitation system still has several issues to address regarding the services included, such as the lack of appropriate emergency interventions, an issue that might lead to unnecessary hospitalizations or even arrests (Israel's State Comptroller, 2007); and the reduced minimum wage that service users are paid in rehabilitative employment frameworks (National Labor Court, 2021).

However, the marked increase in the use of services such as education, leisure time, and social activities (Division of Mental Health, 2008, 2021) might reflect increased efforts to respond to service users' personal goals during recovery, a process attributable to the growing professionalization of the Rehabilitation Unit and modern approaches in the field (Anthony & Farkas, 2012; Corrigan et al., 2008). This trend intensified as the external case management service developed, representing a joint effort between those applying for a rehabilitation basket of services and the professional caregivers to build personally tailored rehabilitation programs as a basis for providing services (Ministry of Health, personal communication, March 13, 2022).

Over the years, a person-centered and recovery-oriented rehabilitation practice evolved to adapt to the spirit of the law and to respond to the new knowledge developed around the world and, of course, to improve the services. With the support of the Ministry of Health, several initiatives and projects were established and recovery-oriented interventions were integrated into the field of rehabilitation (Baloush-Kleinman et al., 2018; Shershevsky, 2022). These include:

1. *The National School for Training in Rehabilitation and Recovery in Mental Health*. The school was established in 2009 at Ono Academic College to provide the employees working in the rehabilitation system with appropriate orientation (Internal Audit Division, 2020).

2. *Development and integration of knowledge based on life experiences of persons recovering from severe mental illness*. This knowledge was integrated into the field of community psychiatric rehabilitation through consumer movements (persons with psychiatric disabilities and their families) at both the advocacy and practice levels (Dvir & Shamir, 2017; Grundman et al., 2021; Lachman et al., 2018; Moran, 2018; Naaman, 2018).

3. *Development of a new role—manager and coordinator of personal rehabilitation plans* (Gelkopf et al., 2016; Pink Hashkes et al., 2013).

4. *Illness and Recovery Management*. Application of the intervention, developed in the United States (Mueser et al., 2002) and recognized as an evidence-based practice (Garber-Epstein et al., 2013; Hasson-Ohayon et al., 2007).

5. *Application of the intervention of readiness for community psychiatric rehabilitation* (Anthony & Farkas, 2012; Baloush-Kleinman et al., 2018).

6. *Social Cognition and Interaction Training*. This intervention is designed to improve social skills among persons with psychiatric disabilities (Hasson-Ohayon et al., 2014).

7. *Narrative Enhancement and Cognitive Therapy*. The intervention aims to reduce self-stigma (Baloush-Kleinman et al., 2018; Roe et al., 2014; Yamin et al., 2012).

8. *Psychiatric Rehabilitation Routine Outcome Measurement and Quality Surveyors: Establishment of the national project* (Moran et al., 2017; Roe et al., 2015, 2017, 2019, 2022).

9. *The development of family advice and support centers* (Shalev, 2017) *and the Keshet Program* (Weiss, 2013; Weiss et al., 2021).

Additional developments that appeared over the years and were part of the rehabilitation basket of services included supported (rather than protected) services, such as colleagues, mentors, supported employment, programs for completing education, and support for academic education (Baloush-Kleinman et al., 2018; Shershevsky, 2022).

What's Next? The Rehabilitation Reform Enters the Third Decade

The Rehabilitation Reform can boast of impressive achievements over the course of the two decades of its implementation. Nonetheless, the community psychiatric rehabilitation system has important issues to address. In our opinion, it will be appropriate to appoint an independent, external committee of experts to examine the state of the rehabilitation system and propose necessary changes for the coming decades. Among the issues a committee of this kind should discuss are the following.

Alongside the significant growth of the rehabilitation system, according to the data, many persons who might be found entitled to rehabilitation services did not apply, and some of those who had gained eligibility did not actually utilize the approved services. These issues should be examined in depth to encourage application to the system and utilization of approved services (Moran et al., 2015).

Another issue regarding the intended beneficiaries concerns the question of whether it is both desirable and possible to provide community-based treatment for persons with psychiatric disabilities who require a certain level of supervision while avoiding creating "mini hospitals" within the community (Segal & Aviram, 1978), and while also overcoming the Rehabilitation Unit's interest to sometimes prefer providing services to persons with a high likelihood of achieving success. Alongside the notable increase in the scope of the rehabilitation committees' activity, it is of great importance to examine tendencies regarding the denial of applications.

It is also worthwhile to evaluate the basket of services and update it, in view of the changes we have mentioned. In this process, specific population sectors and age groups, and existing knowledge regarding community psychiatric rehabilitation practice should be considered. Additionally, the service users' family members should receive adequate support, and appropriate legislation defining their status and rights should be considered.

The issues we have mentioned in the context of the rehabilitation services' tenders must be examined, to guarantee genuine competition and adequate supervision and oversight, while preventing inferior quality in the rehabilitation services.

To promote and protect the quality of these services, we must also recommend to examine, and maybe regularize, the necessary

training and education for working in the community psychiatric rehabilitation field, while also creating an appropriate promotion track which will be crucial for the purpose of maintaining a skilled team within the system.

It is also imperative to decide on priorities for research and evaluation and to allocate independent funds for this purpose, in order to improve knowledge. So far, the research that has been done had to obtain support from outside sources, with limited success. Establishing a permanent fund with an annual budget for research, similarly to the arrangement operated in the general health care field, would support and expand the scientific community dealing with community psychiatric rehabilitation.

Toward the end of the second decade of the Rehabilitation Reform, organizational difficulties arose between the Rehabilitation Unit and the Ministry of Health's Mental Health Division. Among the disagreements that arose were questions about the relationships, management, and control, and even the organizational position of the Rehabilitation Unit. These difficulties might be affected by differences between the professional culture of the medical profession and the social perspective of the Rehabilitation Unit (Europe Mental Health, 2023), as well as by financial interests or interests regarding matters of leadership and control.

Unquestionably, the mental health services must operate as a synchronized and interconnected ecosystem, but on occasions, there will be some friction among the components of the organizational systems comprising these services. Nonetheless, it is of great importance to promote cooperation amongst different parts of the mental health system, and of course, to ensure the proper functioning of both inpatient and ambulatory systems, to guarantee comprehensive treatment and continuity of care for the persons using the rehabilitation services.

Concomitantly, and especially in view of the social and political weakness of the population of persons with psychiatric disabilities, it is critical to encourage the establishment of a public lobby that will take action to place the topic on the public agenda and to preserve, develop, and advance the Rehabilitation Reform.

Concluding Remarks

The Rehabilitation Law is one of Israel's most important social acts and one of the most advanced examples of mental health legislation in the world. Its implementation is one of the key factors which allowed the overall reform in the mental health field in Israel. Its continued application, alongside application of the adjustments it requires, are essential to improve the quality of life of those with psychiatric disabilities, along with their families and the community as a whole.

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