# 6. Inequalities Among Autistic Adults in Israel

In the first chapter, I argued that autism is a social position, while the analysis provided in the second chapter recognized the systemic marginalization of this social position. Building on these two chapters, in this chapter I argue that the discrimination autistic individuals experience must be understood in a multidimensional manner that takes into consideration additional aspects of these individuals’ social position. Otherwise, as Hankivsky & Christoffersen (2008) identified, the SDH perspective fails to recognize the multifaceted discrimination that is an integral part of oppressed individuals’ reality. Utilizing the analytical framework of intersectionality, this chapter also seeks to examine the complexity of autistic adults’ social position, beyond their autistic identity, by demonstrating additional axes of discrimination autistic adults may experience in the Israeli context. I argue that such an analysis is necessary to comprehensively understand inequalities and address them in a manner that will benefit the entire autistic adult population.

In the second part of the chapter, I turn to explore the discourse around the reasons for inequalities among autistic adults in the political arena in Israel. This move is necessary, as the purpose of an intersectional analysis is not to create a hierarchy of discrimination but to allow an exploration of the power structures that nurture marginalization in societies. The section begins by describing those discriminated groups that are being identified in the political arena and those who are not being identified as such and which aspects of discrimination are not being discussed. Three major reasons that are used to explain these disparities are then given and their limits are elucidated. First, the spillover of known social inequalities to the autistic community; second, the numeric rationale that asserts services are not developed because there are too few formally diagnosed autistic individuals to utilize them; and third, that a lack of awareness is the reason for low utilization of services. Building on this analysis, I argue that the current discourse around inequalities among autistic adults fails to recognize some of the key mechanisms that underlie these inequalities. Moreover, I claim that the lack of awareness rationale cultivates discriminatory attitudes toward the discriminated population, thus increasing instead of decreasing inequalities. The section ends by claiming that a demand-oriented services construct, that is, the basic condition upon which the numeric and awareness rationales are reasoned, is in itself discriminatory in the context of inequalities among autistic adults.

Before turning to the analytical sections, two further important points should be stressed. First, while inequalities among autistic individuals have been explored previously, both worldwide and in Israel, the analysis presented in the first section of this chapter is the first to explore inequalities among autistic *adults* in Israel. Whether these are inequalities based on socioeconomic status, proximity to the cultural–economic center, ethnic group, religiosity, gender, or functional ability, none have been previously explored among autistic adults in Israel. Therefore, beyond its analytical contribution, this chapter adds an empirical perspective that is necessary for promoting change in the Israeli political arena. This empirical contribution was, unfortunately, less supported by the quantitative findings, as most of the statistical analyses did not demonstrate statistically significant differences among autistic individuals from marginalized groups and those from privileged groups. As some quantitative finding could indicate on further marginalization, for ease of reading I have included only those findings that were statistically significant and their interpretation.

Second, although intersectional analysis generally requires multiple axes of discrimination to be observed simultaneously, the analysis in this chapter observed just two axes at a time, the social position of autism plus another discriminated social position. In reality, an autistic individual’s social position can be much more complex and may include many discriminated social positions. For example, an autistic individual who lives at the periphery of Israel, as this chapter explores, is discriminated against due to their position as an autistic person in a neurotypical society but also because of the combination of their autistic identity while living in an area that is discriminated against. However, whether this individual is female or male, a Jew or an Arab, an Ultraorthodox Jew or part of the non-Ultraorthodox population, is not explored in this section. This is not because such multifaceted exploration should be overlooked. On the contrary, as later demonstrated, such an approach is essential to understand the complexity of inequalities. It is rather that because the scope of this research was to explore the realm of the autistic social position in Israel, it was not feasible to further explore these inequalities at the same time. Furthermore, most of the interviewees themselves categorized inequalities using one axis at a time. Future research can and should explore multiple dimensions simultaneously.

## 6.1. Discriminating the discriminated – the unequal distribution of marginalization

While the previous chapter analyzed the SDHIs of autistic adults in Israel and established that this population is systemically marginalized, this section analyzes additional axes of autistic identities that are further discriminated against. Utilizing an intersectionality framework, the section explores the groups that were identified by interviewees to be marginalized in the Israeli context due to their complex social position. The following groups were identified as suffering from multiple marginalization: autistic adults from lower socioeconomic groups, autistic adults who reside at the periphery of Israel, autistic adults from the Arab community, autistic adults from the Ultraorthodox community, and female autistic adults. There were conflicting observations regarding autistic adults who are classified as having lower or higher functional abilities. Based on this analysis, I argue that to understand the marginalization of autistic adults in Israel it is crucial to observe other axes of discrimination, otherwise any effort to improve the lives of autistic adults would miss the actual consequences of the SDHIs and could in fact contribute to increased inequities.

### 6.1.1. Autistic adults from a low socioeconomic background

Many interviewees identified socioeconomic status as one of the key social positions that can further marginalize autistic adults in Israel. Given that several discriminatory policies that were identified in the previous chapter regarding SDHIs have been shown to divert services to the private sector, this should not come as a surprising revelation. As private services usually come with high costs, those individuals with greater private capital will naturally have greater access to services they require. At the other end of the scale, this practice leaves autistic adults from less affluent backgrounds in a lower social position and thus further discriminates against them. One example among several mentioned by interviewees and that exemplifies the use of personal capital to access services was given by Gefen, the mother of an autistic adult and an activist in the autism field. Gefen shared an experience her son had while taking part in a military preparatory program:

“They told us from the military preparatory program that it is important for them that he [my son] will have a psychologist […] so we found someone at the north […] on our expenses, yes, with our funds. We got no refunds, none. It is us and the disability stipend [my son gets from the National Insurance Institute (NII)] and that’s it. That’s all.” (Gefen, the mother of an autistic adult and an activist.)

Gefen described how a publicly funded program, a military preparation program, asked her to provide a therapist who could assist her son during the year he was expected to be enrolled in the program. As mentioned in the previous chapter, autism has been excluded from the mental healthcare reforms. This leaves a family’s personal capital, which also includes the NII stipend, as the only source of funding for these services. The fact that a publicly funded program relies on a household’s personal funds to provide an essential service de facto means that autistic adults who cannot afford these services are excluded from accessing these types of public programs. Put another way, autistic adults from a lower socioeconomic background are not just marginalized because they do not have access to the same mental healthcare services as other autistic individuals but also because publicly funded programs who request these services are not accessible to them because they cannot afford them. Gefen’s example also highlights the centrality of the military in the Israeli social context. Most young Jewish individuals, including those with autism, see their ability to be recruited and engage in meaningful military service as an integral part of the development of their identity[[1]](#footnote-1). Although military programs dedicated for autistic individuals include a supporting envelope and are publicly funded (see, for instance, the Roim Rahock Program, 2021), additional related services are not included, as this example illustrates. Thus, preventing the participation of autistic individuals from a low socioeconomic background in these services, in the Israeli context, further marginalizes them as it hampers their ability to fully participate in one of the central institutions in society.

This example allows further inferences to be made about the marginalization of autistic adults of a lower socioeconomic status more broadly. As the previous chapter illustrated, autistic adults’ requirements for mental healthcare services and additional complementary services are enormous. Although the request for treatment in this example came from a public provider, most of the time the use of private services is not the result of an external demand but due to a genuine need. An autistic individual from an affluent background who can afford these services can have access to additional social determinants that autistic adults of a lower socioeconomic status cannot. Agam, the mother of an autistic adult, described in her interview an instance that exemplifies the additive value of private services:

“We started to feel it is not OK he is still living with us, but he did not show any signs of wanting to leave home. […] I approached a psychologist [who specialized in similar cases] and he assigned us to another psychologist from his team. We started a project to help him [my son] to leave home. And we did it wisely as we had been instructed, and he found an apartment in Tel Aviv.” (Agam, the mother of an autistic adult.)

Agam’s experience demonstrates how privately funded services could open the door for additional SDHs. In this case, approaching a special psychologist privately and paying from the family’s capital allowed her autistic adult son to find an apartment. Although later in the interview Agam described how this residential arrangement was a mistake that led to a deterioration in her son’s emotional wellbeing, it demonstrates the link between private services and SDHs. An autistic individual from a less affluent background who cannot access the services they need would be deprived from participation in additional aspects of life such as housing, employment, or higher education. It should also be briefly mentioned, although this was extensively analyzed in the previous chapter, that not providing a publicly funded diagnosis of autism further discriminates against autistic adults of lower socioeconomic status as it prevents them from accessing the services that are available for this population.

In addition to the direct effect socioeconomic status has on an individual’s ability to purchase private services, it also indirectly affects the capacity of an individual to dedicate time to the search for services. Another policy issue that was found to be a barrier, mainly to social services and therefore not covered in the previous chapter, is the absence of one body of knowledge that consolidates all of the relevant services for autistic adults. No formal or informal body anywhere in the system, whether MOLSA or the MoH, has a clear map of all of the public and private services that are dedicated and available for autistic adults. Various professionals who were interviewed mentioned efforts to create such a body of knowledge in their organization. An example that did receive the support of MOLSA was carried out by Avnei Dereh (Avnei Dereh Organization, 2017); however, this effort has yet to be completed and has not been updated since 2017. Given these circumstances, the time and emotional energy required to actively look for services can easily lead to inequalities. Ben, the director of a program focused on autistic adults, described this indirect effect very accurately:

“I think that inequality really [exist], that parents that are busy with their day-to-day struggle to bring food home they have less time to go and visit and explore the services [that are available]. I think that the information is not accessible enough and that a parent that is not going from place to place and does phone calls and go to the social worker again and again, most likely will not find us [the program he manages] or other services. I had a meeting with parents […] and one of the mothers told [me] that this is the first time she heard about our program. And it was a mother that works in two jobs from morning to evening. She does not have time to deal with it. So inequality is [also manifested] in the access to knowledge.” (Ben, a professional who works with autistic adults.)

Ben described in this quote how a lack of accessibility to knowledge about services and rights is marginalizing autistic adults from less affluent backgrounds. The woman Ben portrayed, who runs from one workplace to the next, could not invest the time that was required in the search for services, given the current decentralization of knowledge. Although later in the interview Ben clarified that the autistic son of the woman described in the quote did not meet the criteria to join the program he managed, her son’s barrier to this service resulted from his position in a lower socioeconomic class coupled with the fact he is autistic and needed the service. The idea that material capital, socioeconomic status, is linked to the ability to acquire knowledge, or more broadly to acquire social capital is not new (Lin, 2000), nor is it a stranger to health inequalities (Kawachi, Takao & Subramanian, 2013). However, in the context of this work, it is essential to stress its connection to marginalization mainly because of its specific manifestation in terms of the absence of a centralized body of knowledge of available services.

Although direct statistically significant differences among socioeconomic classes were not found during the qualitative analysis of the survey findings, this analysis indicates that the current marginalization of autistic adults is indeed as argued above, directing those who can afford it to private services. The analysis shows that among those who attempted to purchase private health insurance and private rehabilitation insurance, there was on average a greater number of barriers to healthcare services (see chapter 4, tables 4.1 and 4.2) than among those who did not (Avg=9.40 (SD=5.88) vs. 6.12 (5.17); t (110) = -2.2, p < 0.05, and 10.83 (5.99) vs. 6.05 (5.07); t (110) = -3.025, p < 0.01, respectively). These findings show that the worse the discrimination is, the higher the likelihood an autistic individual, or their family, will turn to the private market as a solution. As private services are costly, those who are less socioeconomically privileged are further marginalized. It can be concluded, mainly from the qualitative findings but also from the interpretation of the quantitative findings, that both the need to fund services and the need to dedicate time to search for services in the Israeli context are marginalizing autistic adults from a lower socioeconomic background.

### 6.1.2. Autistic adults who live at the periphery of Israel

The issue of inequalities based on geographical proximity to the cultural and economic center of Israel, which is also located in the geographically central district of Israel, was mentioned by many interviewees, including autistic adults, parents, and professionals. This social dimension increased the marginalization of autistic adults in two ways: a lack of professionals in the periphery and distance from essential services. Calanit, for example, the mother of an autistic adult, a professional who works with autistic adults, and an activist in the autism field, when asked about inequalities among autistic adults, mentioned that:

“There are differences of […] periphery and center, for instance there is a huge lack of speech therapists which is one of the most important professions [for autistics …]. As far as you go from the center the shortage is greater, beyond the drought line[[2]](#footnote-2) there is also drought of speech therapists. There are none, just none. Even if you have money, none.” (Calanit, the mother of an autistic adult, a professional, and an activist.)

Calanit resides in the center of Israel but is an activist for an autism advocacy organization and is therefore familiar with service availability across Israel. She reflected on the awful situation those who live in the periphery and need to find a speech therapist are facing – a complete drought, as she framed it. At the end of this quote, Calanit added an important distinction between two social positions that often overlap in Israel, namely residency in the periphery and low socioeconomic status. According to her, the lack of practitioners in the periphery is so severe that it cannot be mediated by personal wealth, as it can be in the central region. Autistic adults who reside far from the center of Israel are thus marginalized more than their counterparts who reside in the center of Israel, due to the shortage in professionals.

In addition to the shortage of professionals across Israel, the uneven distribution of public services across Israel also affects the ability of autistic adults and their families who reside in the periphery to access services and thus discriminates against them. For instance, the only psychiatric clinic recognized by the MoH as a specialized service for autistic adults (see chapter 5.3.2) in Israel, Keshet clinic, is located in Ramat Gan, in the center of Israel, while the only psychiatric ward designated and specialized in care for autistic adults is located in Jerusalem. Other services for autistic adults who reside in the periphery are scarce, including residential and employment opportunities. Dr. Yair, a psychiatrist working with autistic adults in the center of Israel, noted from his experience with the Keshet clinic that those who arrive there are “mainly people leaving between Hadera and Gedera”[[3]](#footnote-3) (Dr. Yair, a psychiatrist working with autistic adults). Dr. Efron, a psychiatrist working with autistic adults in the Jerusalem area, described in his interview another way in which distance can affect therapy:

“But let’s say a parents’ group, so if someone that is [residing in a hostel] here [in the Jerusalem area], even if he is from Be’er Sheva [a city in the south of Israel] and he needs to drive by car, or worth that he needs to go by bus and arrive to the central bus station in Be’er Sheva and then from there to the central bus station in Jerusalem, then from Jerusalem to the hostel, if he doesn’t have a car […] because of the long way he will not participate in the parents’ group, there are very low chances he will.” (Dr. Efron, a psychiatrist working with autistic adults.)

Dr. Efron described the long and exhausting journey a parent whose child is enrolled in a residential home in Jerusalem must take to access services. Distance from services, Dr. Efron explained, does not just affect the availability of services but affects compliance with services. Dr. Efron’s description also illustrates how being from a higher socioeconomic status, manifested by having a car in the example he gives, would mitigate the barrier caused by living in Israel’s periphery. An autistic adult from a lower socioeconomic background who resides in the periphery would therefore suffer from combined marginalization.

For the quantitative analysis of the survey’s findings, a one-way ANOVA was performed to identify differences among residential areas. Residential areas were defined according to the MoH’s seven districts (Ministry of Health, 2019), to allow more accurate observations of the discrimination against autistic adults who reside at the periphery than those presented above. The city or village of residency the responders provided was converted into the relevant district. No statistically significant differences between the average number of barriers to healthcare or in the number of unmet additional needs were observed (according to Levene’s test of homogeneity of variance, the distribution of the variables was homogeneous, p<0.01, in both instances). However, there was a statistically significant difference in the responders’ assessment of a family physician’s ability to address the needs of autistic adults (F (between groups df - 6, within groups df - 73)=2.89, p<0.05). Scheffe’s post hoc test demonstrated a statistically significant difference between the average perception of the family physician between south district and north and Jerusalem districts (p<0.05, 95% confidence interval (CI)=0.02–3.28 and p<0.05, 95% CI=0.10–3.49, respectively). No other significant differences between districts were observed. This finding suggests that the lack of knowledge among professionals with regard to autistic adults is worse in the south district than in other parts of Israel. It also strengthens the claim that autistic adults who live in the periphery are further discriminated against due to their intersectional identity.

To conclude, autistic adults who reside in the geographical periphery of Israel suffer from additional marginalization. This marginalization is the result of a lack of relevant professionals in the periphery and a lack of knowledge among those who do provide services, especially in the south of the country. The lack of public services and the distances that individuals are required to travel to access services also directly affect compliance. It is debatable whether this marginalization could be mitigated by personal wealth; however, it is clear that this additional social dimension, of an individual’s area of residency, is affecting the lives of autistic adults.

### 6.1.3. Autistic adults from the Arab minority

Another social group that was recognized by professionals, parents, and autistic individuals as being discriminated against is the Arab minority. Autistic adults belonging to the Arab minority are marginalized in a similar way to autistic individuals who come from a lower socioeconomic background and those who live in the periphery, due to the shortage of professionals and public and private services dedicated for this community. Shai, a professional who works with autistic individuals from the Arab minority for one of the provider organizations, described in his interview:

“There are a lot of parents’ initiatives, and a lot of organizations, businesses that have, for instance, programs of [software] quality assurance for guys with autism… all in the Jewish sector. There is not even one project like this, or that resembles, a creative [project], in the Arab society. There is none. Really none.” (Shai, a professional who works with Arab autistic individuals.)

Although speaking about private services and not public ones, Shai highlighted the complete absence of services for autistic adults from the Arab population. His observation was shared by many interviewees who also mentioned the lack of services for Arab autistic adults. Arab autistic individuals are thus marginalized because of their social position that combines their autistic identity with their Arab identity. In addition to the absence of services for these adults, interviewees also raised the lack of professionals for this community. Gefen, for instance, the mother of an autistic adult and an activist in the autism field, mentioned this issue in her interview:

“Another example that I am familiar with… I know that speech therapists, there are not enough speech therapists that know Arabic… so they teach sign language [for instance], they are signing in Hebrew… not Arabic, because there no one who speaks, there are not enough speech therapists who speak Arabic.” (Gefen, the mother of an autistic adult and an activist.)

Gefen started by describing the shortage of speech therapists who speak Arabic. This shortage, in her opinion, is affecting the ability of children with a hearing impairment to acquire their mother-tongue sign language. Although not directly referring to autistic adults, this example illustrates the possible ramifications the scarcity of professionals could have for autistic adults. As detailed extensively in chapter 4, regarding the barriers to accessing the healthcare system, communication differences are at the core of autism. Given that the mother tongue of Arab autistic individuals is Arabic, not having an Arabic-speaking practitioner could potentially further complicate the ability to communicate and exacerbate this barrier for autistic adults. To the best of my knowledge no research has been conducted among adults to explore the influence of mother tongue on service utilization and outcomes; however, in autistic children their mother tongue has been found to be influential in helping them to reach communication goals and improve their social skills (St. Amant, Schrager, Peña-Ricardo, Williams & Vanderbilt, 2018). The implications of a shortage in mother-tongue-speaking professionals are probably similar in adults. It can be concluded, therefore, that the intersectional identity of Arabic autistic adults is further marginalized by the lack of Arabic-speaking professionals.

Considering the intersectional identity of Arabic autistic adults, the death of Iyad El Hallak must be mentioned. On May 30, 2020, an Arab autistic adult was shot to death in the Old City of Jerusalem by a police officer who thought he was a terrorist (Kaplan, 2021). El Hallak did not understand the order from the officer to stop so he became scared and ran away; the officer then chased and shot him (Brieiner, 2020). Although this was not the first case of a police officer shooting a disabled individual in Israel, nor the first time an Arabic person with a disability has been shot, this case exemplifies the importance of understanding the implications of this intersectional identity in the Israeli context (see Weishut, Benninga, Aitchison, & Steiner-Birmanns, 2021, on police violence in Israel toward people with mental disabilities). It was El Hallak’s complex Arabic autistic identity in the context of Israel that resulted in his death[[4]](#footnote-4) (Kaplan, 2021; Whitaker, 2010), a context in which Arabs are also discriminated against in the healthcare system (Ziv, 2016; Keshet & Popper-Giveon, 2018). Being either a neurotypical Arabic individual or a Jewish autistic individual could probably have prevented this tragic incident. To sum up, in the Israeli context the social position of this intersectional group is further discriminated against compared with their Jewish counterparts due to an absence of services, a lack of trained professionals who speak Arabic, and unfortunate discriminatory practices toward the Arab minority.

### 6.1.4. Ultraorthodox autistic adults

The experience of Ultraorthodox autistic adults is not very different from that of Arab autistic adults. This was mostly mentioned by the professionals who were interviewed and who work with this population, because while attempts were made to interview informants from this community, these attempts failed. This social group was also identified as suffering from marginalization due to their intersectional position. A lack of services and the absence of trained professionals were again prominent factors that were mentioned as marginalizing this population. Bat-El, an advocacy lawyer who works with the autism community, shared the case of a child she represented that illustrates this marginalization:

“Really they [the Ultraorthodox community] have great lack of professionals. One incident was of an autistic child from Bnei Brak[[5]](#footnote-5) […] that spoke Yiddish at home. It appears they don’t have a Yiddish communication kindergarten in Bnei Brak, but they do have in Jerusalem. The physician and the psychologist recommendation were that the kindergarten will be in Yiddish […] and we fought that the child would have a public funded transportation to Jerusalem.” (Bat-El, an advocacy lawyer who works with the autism community.)

The case Bat-El describes highlights the great shortage of professionals dedicated for the Ultraorthodox community. It further demonstrates that, as in the case of Arabic autistic adults, this shortage occurs because there are language barriers to some sections of this population. However, this incident also demonstrates another important issue regarding the marginalization process of autistic individuals from minority groups. First, having a legal mandate to be provided with services, as children do, assists in demanding rights and reducing the marginalization of disadvantaged communities. Therefore, the SDHIs mentioned in the previous chapter, especially those that result from an absence of policy, disproportionally affect autistic individuals from marginalized communities. Second, there are immediate solutions that can assist in the short-term to overcome the existing discrimination against autistic adults from disadvantaged groups, such as organizing travel arrangements.

In addition to the language barrier Ultraorthodox autistic adults face when accessing the scarce services that are available, another mechanism was mentioned that limits the access of this group to services – cultural barriers. Dr. Rotem, a psychiatrist working with autistic adults including Ultraorthodox autistic individuals, explained in her interview:

“Among the Ultraorthodox Jewish population and among the Arab population also […] it is much harder to diagnose and think of differential diagnosis for these patients. I mean, for instance, [at] Ma’ayaney Hayeshua[[6]](#footnote-6) I was always sitting with the clinic coordinator, a Hasid Gur[[7]](#footnote-7), that translated to me culturally what I am seeing. He was a social worker.” (Dr. Rotem, a psychiatrist working with autistic adults.)

Dr. Rotem opened this quote by explaining that psychiatric examinations are much more difficult to conduct with autistic individuals from the Ultraorthodox and Arab communities. Therefore, she added, a cultural mitigator who can assist with translation and interpretation is needed. This implies that, without cultural accommodations, Ultraorthodox autistic adults would not be given proper care. In other words, although not directly discussing the shortage of professionals or services, Dr. Rotem pointed to cultural barriers as being another barrier to accessing general services for autistic adults. Her claim is well supported by the literature, as culture has been found to affect the screening (Soto et al., 2015), recognition (Grinker, Yeargin-Allsopp & Boyl, 2011), and treatment (Ennis-Cole, Durodoye, & Harris, 2013) of autistic individuals. This also explains why it is not only Ultraorthodox autistic adults who speak Yiddish who are marginalized in Israel but also those who speak Hebrew. At the beginning of her quote, Dr. Rotem mentioned the Arab community as a community that suffers from this marginalizing factor as well, stressing this barrier is also relevant to other social groups. To conclude, Ultraorthodox autistic adults represent another group that is marginalized in the Israeli context due to a lack of designated professionals and services that are appropriate for their culture and language.

### 6.1.5. Female autistic adults

Autistic women were identified as another social group that is discriminated against in the Israeli context. Gender discrimination is not unique to autism (Fogiel-Bijaoui, 2016), nor is it specific to the Israeli context (Heise et al., 2019); nevertheless, in the context of autism there are two distinct features to this discrimination that are explored in this section. First, unlike common discriminatory practices toward women, in the context of autism women not only constitute a social minority but also an absolute minority. This phenomenon, which is derived from scientific and medical perceptions of autism, has implications for access to services. In addition, the neglect of gender-specific services has consequences for women’s ability to have a family, which in a pronatalist nation such as Israel (Portugese, J., 1998) can greatly affect autistic women. The intersectional identity of adult autistic women in Israel, as this section explores, deprives them of the resources available to autistic adult men.

In the latest metanalysis that explored the male to female ratio of autism globally, the estimates ranged between 4.20 (95% (CI) 3.84–4.60) and 3.32 (95% CI 2.88–3.84), depending on the research quality (Loomes, Hull, & Mandy, 2017). In Israel, the ratio was reported to be higher in certain birth cohorts, reaching up to 5.6 in some (Raz, R. et al., 2014). The cause of this disparity between the numbers of autism cases in males and females is complex; however, as Dr. Yair, a psychiatrist working with autistic adults, mentioned in his interview, it is rooted in biases related to the diagnosis process:

“As much as it [autism] is concealed, let’s say the situation of high functioning autism can be regarded as concealed disability, in women it is apparently even more concealed. Our models of how it [autism] looks like is based on men. The theory on the amplification of the male mind is one example […] identifying it requires I think more experience, more qualifications, and understanding of how autism looks like in women. And it looks a little different.” (Dr. Yair, a professional working with autistic adults.)

The process of diagnosing autism, Dr. Yair explained, is based on a model that is ill equipped to identify autistic women. Therefore, a diagnostician must be highly trained and knowledgeable to be able to diagnose autistic women. Dr. Yair’s explanation portrays a context that favors autistic men. This corresponds with the literature, which reports a distinct phenotype in autistic women and gaps in their diagnosis (Gesi et al., 2021). Similar to acute coronary diseases, which clinicians frequently fail to recognize in female patients (Shah et al., 2015) thus creating gender inequalities, autism is less diagnosed in women and therefore this is discriminatory toward women. Coupling these circumstances together with the SDHIs identified in the previous chapter, specifically the lack of knowledge among professionals and the inability to obtain a publicly funded diagnosis of autism in adulthood, it can be inferred that autistic women are another marginalized group in Israel.

In the context of this male to female ratio, autistic women in Israel find themselves discriminated against twice. There are almost no services available dedicated to the needs of autistic women, and in group services such as social groups they often find themselves alone. An example of this numerical effect was mentioned by Sigal, the mother of an autistic woman and an activist in the autism field:

“For years… years… they [the organization] are arranging a course, a workshops for parents […] and when I called and asked them, ‘wait, once again I am the only girl’, I mean the mother of a girl, they answered – ‘yes’. And I replayed I have a group of 40 mothers [of girls].” (Sigal, the mother of an autistic woman and an activist.)

Sigal described how without a dedicated effort to recruit autistic women or in this case the parents of autistic women, the probability of having a female participant in a group is low. This low participation of women in groups creates two problems. First, the discourse within the group may be partially irrelevant, as the issues that women face are somewhat different from the issues faced by men. Second, it appears that this gender imbalance causes women to forego these services. As Gila, the mother of an autistic child and a professional working with autistic adults described: “There are not enough girls, and it is not because they weren’t born, but because they are really scared […] in every group you have always eight men and one girl” (Gila, a professional and a mother of autistic child). Whether it is because women are scared to participate, as Gila described, or because of the irrelevance of the services, it is clear that due to the current numerical bias toward autistic men, autistic women are being discriminated against in group services. However, Sigal’s final sentence demonstrates that even in the current imbalanced context there are ways to reduce its effects by taking the initiative and trying to expand a group to include more autistic women.

In her interview, Sigal further explained what is missing from current services when she outlined her ideas on the types of future services that need to be developed:

 “Gender intervention [… it will include] all the things that are related to being assertive, to hygiene, all the daily things that differentiate the girls along the years. Also, the aspect of clothing, walking […] the issue is protectiveness.” (Sigal, the mother of an autistic women and an activist.)

The issues Sigal envisioned that should be covered in gender-specific services for autistic women (and girls), including hygiene, clothing, walking, assertiveness, and protectiveness, are currently not being addressed. It is not just that group services are irrelevant, Sigal’s vision illustrates that the absence of services dedicated for autistic women is much worse than this. Daily aspects of life, such as hygiene and protection, are not being addressed, leaving autistic women without the services they need. Not having this assistance prevents them from acquiring the skills they need to enable their full participation in the community. Cochav, an autistic woman, shared her feelings about this demoralizing situation:

“I think that, biologically speaking, the fact that I got a late diagnosis means it will take time until I will find a partner that I could establish a family with, I am one of those who interested in having a family, all by the book […], you can diagnose a man in his 40s but a woman at her 40s needs to go through fertility treatments […] some prioritization is needed […] You need to have more researchers more psychiatrists that focus on us [autistic women…] there is none, no researchers, no psychiatrists that would agree to meet with us to specialized in us, we are not desirable enough because we are not an audience, we cannot bring the money […]. This is sad. And yes, I mean that everywhere [I go] I know that I am a minority. When I am dealing with autism, I am alone.” (Cochav, an autistic woman.)

In the beginning of her quote Cochav expressed her disappointment at being diagnosed later in her life. She assessed the consequences of obtaining the assistance she needed only late in life and concluded that she will have to go through fertility treatments. Cochav, who wishes to have a family “by the book” as she puts it, in the Israeli cultural context, expressed in her own words the manifestation of discrimination against autistic women in Israel. The combination of being an autistic woman in the context of a lack of knowledge among professionals, an inability to obtain a publicly funded diagnosis, and living in a pronatalist nation means that autistic women are not able to fulfill their desire to establish a family and be part of the community.[[8]](#footnote-8) The second part of Cochav’s quote highlights how autistic women in Israel are marginalized. Resonating with the words of Dr. Yair, Cochav talked about the absence of dedicated researchers and psychiatrists who specialize in autistic women. Speaking from her own experience as the oppressed, she voiced difficult feelings of neglect and of being left alone by herself to deal with her life struggles. Whether this situation is the result of a lack of consumer power, as Cochav asserts when she says “we are not an audience, we cannot bring the money”, or whether it the result of structural discrimination against women, the consequences are clear.

Several statistical tests were performed on the qualitative data to try and capture the marginalization of autistic women. A chi-square test of independence was performed to identify sex differences in the use of healthcare services. A statistically significant relationship between the number of hospitalizations in the past year and sex was observed, with women being more likely to be hospitalized (*X2* (1, N = 112) = 7.169, p<0.01). In addition, a statistically significant relationship between the use of mental health services in the community and sex was observed, where women were once again more likely to be enrolled in services than men (*X2* (1, N = 112) = 7.202, p<0.01). These findings might signify that there are better health outcomes among autistic men than women, demonstrating inequalities between these two groups. Nevertheless, they could also indicate better access to healthcare services among women and not necessarily worse health outcomes that require treatment. This assumption is less likely given the marginalization autistic adults experience in the healthcare system in Israel, as the previous chapter demonstrated, which prevents all autistic adults from accessing services. Furthermore, a statistically significant association was demonstrated between having a guardian and sex (*X2* (1, N = 112) = 6.510, p<0.05). This association could suggest that the differences in health outcomes between men and women seen in this dataset are a result of independent decisions that the women who participated in this survey made in relation to their health. Although the quantitative findings were inconclusive, it is clear from the qualitative findings that autistic women are marginalized in the Israeli context, with their intersectional social position preventing their equal access to services.

### 6.1.6. Autistic individuals from the LGBTQ community

As gender and sexuality cannot be regarded as binary, and despite the discrimination against autistic individuals who consider themselves to be part of the lesbian, gay, bisexual, transsexual, transgender, and queer (LGBTQ) community not being directly expressed, given the prevalence of autistic individuals who see themselves as part of this community (Warrier et al., 2020) and because this community is oppressed in Israel (Kuperman & Sznitman, 2016), it is crucial to discuss this intersectional identity. Despite there having been no studies that have explored the scale of the gender-diverse autistic adult community in Israel, the interviewees suggested it has a notable presence. For example, Zohar, an occupational therapist working with autistic adults, mentioned that “Gender and sexual preferences, there is great confusion, a lot of trans[genders]” (Zohar, a professional working with autistic adults). The scientific literature shows that gender concerns and gender dysphoria are indeed common issues among autistic adults and suggests a need to create suitable services that address these concerns (Jacobs, Rachlin, Erickson-Schroth & Janssen, 2014; van Schalkwyk, Klingensmith & Volkmar, 2015; Glidden, Bouman, Jones & Arcelus, 2016; George & Stokes, 2017). An example of why specific services might be needed for LGBTQ autistic individuals was given by Barak, an autistic adult interviewed together with his male autistic partner, Shlomi:

 “People do not understand our relationship because they try to classify us into some kind of category, usually it will be gays because we are two men […] it is not suitable, I met gay people they are nothing like us. The idea of their [gay] relationship looks exactly like a relationship between a man and a woman, just between two men, they still have roles that they play with each other […] you are never free to really share your life with another person, there is no such thing in our relationship.” (Barak, an autistic adult.)

Although not directly discussing services, Barak’s description may provide an insight to the importance of such services for autistic adults from the LGBTQ community. In this quote Barak revealed the gap between the definition he assigns to the term “gay”, which makes him not want to identify as gay, and the accepted definition of men who have sex with men. The importance in understanding this gap arises from the consequences of being part of the LGBTQ community, whether Barak likes it or not. These consequences in the Israeli context can be diverse, but as Shlomi described in another section of the interview in his case they were harmful. When he revealed his sexual orientation, he was expelled from his community and his close family stopped all communication. Services that are dedicated to autistic adults from the LGBTQ community should address among other things the discrepancy between the perception autistic individuals assign to the community and the actual effect being part of this community has on their life.

To conclude, gender is another social intersection that should be accounted for in the examination of autism as a social position. As this section has illustrated, autistic women are discriminated against because they are less frequently diagnosed than men and also have fewer dedicated services that can assist them in addressing their daily needs. In the Israeli pronatalist context, this means a reduced ability to achieve a “desirable family”. Although autistic adults from the LGBTQ community were not identified as being marginalized, the interviews demonstrated that this intersection of identities might also require a dedicated approach.

### 6.1.7. Functional inequalities

Functionality is a category that is assigned to autistic individuals to define their capacity to participate in the community. There is no clear definition of functionality, as each autistic individual is located on several axes that can affect their functionality. Whether it is the comprehensiveness of an individual’s autistic traits, their cognitive ability, their level of cooperation and behavior, their personal habitus, or their variations in functionality in different contexts; all of these play a part in defining an individual’s functionality (see Alvares et al., 2020, Yergeau, 2010). As many interviewees pointed out, among them Tuvia, the father of an autistic adult individual: “you saw one autistic, so you saw one autistic, there aren’t two that are the same” (Tuvia, the father of an autistic adult individual). It should be noted that the inter-ministerial team for the regulation of treatment for the population of people with autism, led by MOLSA, also recognized the difficulty of using functionality as a binary definition and they suggested that there should be three aspects considered in the calculation of needs (Vagshal, 2013). Nevertheless, the category of functionality is used by various stakeholders to subdivide the autistic community. Raz and colleagues (2018), for instance, mentioned in their article the use of this category by members of Alut, which is the largest and oldest parent organization in Israel, to differentiate themselves from ACI (the Autistic Community of Israel).

In the context of this section, functionality was expressed by different interviewees as a category that divides the autistic community into distinct social groups, with each group having different access to services. In other words, the interviewees used this category as another intersectional dimension and argued it marginalizes certain autistic adults. Although this category has no empirical grounding, as I discussed above, its usage by actors in the autism field mandates its exploration. In contrast to the other social categories discussed above, however, and as the following discussion demonstrates, there was no agreement regarding who is marginalized. Some interviewees argued that those individuals with lower functional abilities are more likely to receive fewer resources for their needs, while others expressed the exact opposite opinion, claiming that those individuals with higher functionality receive less than they need.

Noa, an activist in the autism field and the mother of an autistic adult who has many difficulties, was among those who argued that those with “lower functional abilities” are discriminated against the most:

“When you talk about the younger ages […] whoever has autism is defined [as having] 100% disability. It is not differential. Today it is changing to the right direction, in my mind, those who have lower functioning will be deserve more special services […] There is a group, of a very very high functioning, that receive services a little more that they deserve, in some areas, in others area they are getting less. But I think it is an urban legend that we are [autistic individuals with lower functional abilities] getting more, we are getting more because we need more.” (Noa, the mother of an autistic adult and an activist.)

Noa began by criticizing the current policy regarding autistic children. As there is no differentiation according to functionality all autistic individuals receive the same stipend, which according to her is not right. Then, after arguing that those with lower functionality should receive more, she turned an accusing finger toward the undefined group of “very very high functioning” and argued they are getting too many resources. Although it seems she recognized in the very same sentence that not all of the needs of this group are met, her claim at the end of the quote that those with low functionality receive help according to their needs although in absolute terms they are receiving more demonstrated that she did not really recognize it. In other words, Noa asserted that resources should be divided in an equitable manner, which takes into consideration the functional level of the individual. Lower functioning autistic individuals should receive more, in contrast to the current situation where in some cases high functioning autistic individuals are receiving more than they need.

At the other end of the functionality spectrum, Dr. Rotem, a psychiatrist working with autistic adults, claimed in her interview that those who are high functioning are receiving less:

“There is a problem in the access to experts of those people in the spectrum that are really high functioning. There are the rights organizations and family organizations such as Effie or ACI, that have lists of therapists [that can assist high functioning autistic individuals get access to experts]. But this is not formalized because the social services do not deal with them. There is no one that coordinate, refer, and send [high functioning individuals] to those clinics. High functioning [autistic individuals] need to take care of themselves.” (Dr. Rotem, a psychiatrist working with autistic adults.)

In contrast to Noa, Dr. Rotem recognized a gap in the referrals to services of high functioning autistic adults. She argued that therapists for high functioning autistic adults are inaccessible. No formal body and specifically MOLSA, who are extensively involved in the care of low functioning autistic adults, assembles a list of therapists and refers high functioning autistic adults to them. She added that such lists are available at advocacy organizations, but that a high functioning autistic adult must be proactive to find and obtain them. In that sense, high functioning autistic adults are discriminated against because in comparison with the access to services for low functioning adults these services are less accessible.

For some interviewees, however, the categorization of autistic individuals as either high or low functioning does not capture the full extent of the autistic spectrum. Bat-El, for example, an advocacy lawyer who works with the autism community, categorized the spectrum into three groups, arguing that is those individuals with a mid-level of functionality who are being discriminated against. In her interview, when discussing inequalities among autistic adults, she claimed that:

“The middle functioning, there are less services available for them […] the higher functions have housing options in the community, to the lower functioning there are the hostels [residential homes], and the middle need, how you call it… extensive community leaving, extensive support. This is really missing.” (Bat-El, an advocacy lawyer who works with the autism community.)

Working closely with the autistic community, Bat-El recognized that the current living arrangements are marginalizing autistic individuals with a mid-level of functional abilities. Although this category is not properly defined, according to her these autistic individuals could live in the community but would need some extra care. Currently, this section of the community has no residential options available to them, disadvantaging their social position. Bat-El’s point, taken together with those of Dr. Rotem and Noa, can lead to one of two conclusions. The first is that inequalities according to functional level should be seen as a complex issue, where in respect to some services low functioning individuals receive more help while in respect to other services high functioning individuals receive more help; however, neither group can be considered as marginalized. The second, which also corresponds with the position that the term “functionality” is arbitrary, is that this term does not assist in helping to understand the needs of autistic adults, their access to services, or their social position.

Despite the “low functioning” and “high functioning” categories not being measured in the survey, as they are not defined categories, two possible proxies of “functionality” were controlled for in the survey. First, who was it that completed the questionnaire, on the assumption that those who are “high functioning” completed the questionnaire themselves and those who are “low functioning” had a family member complete the questionnaire for them. The second was whether an individual had a legal guardian, assuming those who did not have a guardian were high functioning. The analysis demonstrated that where individuals’ questionnaires were completed by a family member and among those individuals who had a legal guardian there were on average a significantly higher number of barriers to healthcare services (see chapter 4, tables 4.1 and 4.2) than among those who completed the questionnaire themselves or did not have a legal guardian (Avg=7.98 (SD=5.30) vs. 5.24 (5.11); t(110) = -2.278, p<0.01, and 7.88 (5.22) vs. 5.67(5.30); t(110) = -2.181, p<0.05, respectively). While these findings could indicate that “low functioning” autistic adults face more barriers to accessing healthcare services, they could also be interpreted as perceived barriers by a family member or guardian as opposed to the actual experience of the autistic individual themself. It should be noted that other analyses of the survey’s findings conducted to demonstrate differences between these groups were not found to be statistically significant.

Although the quantitative analysis might suggest a difference between “low” and “high functioning” autistic individuals in terms of the number of barriers to accessing the healthcare system they experienced, these categories are not well defined, and the proxies used for their measurement might be biased. In conclusion, trying to categorize individuals with very different needs as either low, middle, or high functioning when the concept of functionality is not well defined, as the qualitative analysis demonstrated, might create more confusion and is not helpful in understanding not the services needed and not differences between groups.

### 6.1.8. Multiple intersections

Although multiple intersectional social positions are not covered in the analysis above, as the introduction to this chapter states, it is crucial to discuss their importance in gaining an understanding of inequalities. Dr. Rotem, a psychiatrist working with autistic adults, was quoted above in regard to the cultural sensitivities needed when treating Ultraorthodox and Arab autistic adults. In a later part of her interview, she added that any reference to these intersectional communities being as one is superficial. She emphasized that the Ultraorthodox community was:

“heterogeneous…because Ma’ayanei Hayeshua is after all at the center of the country, and [some among] the Ultraorthodox Jewish population has referees in the area of mental health […] therefore some of them got better care then the secular population […] on the other hand there are also discriminated populations… also there [in the Ultraorthodox community] sometimes the parents do not know how to call for help or they are from Hasidut [a congregation] that is not particularly strong […]. Among the Arab population it is also not that simple, here too there is heterogeneity. I mean that there are parents from Ramla [a city close to the center of Israel], for the sake of the discussion, that were very powerful […] much more knowledgeable and goal directed, but it is clear to me that in the geographic periphery the shortage is enormous.” (Dr. Rotem, a psychiatrist who works with autistic adults.)

Dr. Rotem’s careful observations of the Ultraorthodox Jew and the Arab communities illustrate how titles and identities can mask much more complexity beneath them. Regarding the Ultraorthodox Jews, she created a distinction between different conjugations, pointing to resources as mental health referees that can work as mediators. The Arab community is also diverse, for example Bedouins from the Negev in the Southern District of Israel are not in the same condition as the Arabs residing in Jaffa or Ramla in the center of Israel. Her point underlines the importance of using a multidimensional intersectional analysis to understand inequalities. Although she was not the only person who referred to inequalities in a complex fashion, such a multifaced perspective was rare among the interviewees. The absence of this type of discourse may either signify the difficulty of studying it or, more likely, signify the limited nature of the discourse in Israel, which fails to acknowledge the complexity of populations that suffer from discrimination and instead focuses on an “us and them” dimension (Kahanoff, Lurie & Masalha, 2019).

To conclude, this section analyzed and demonstrated the intersectional identities of autistic adults in Israel. The section argues that to fully understand the marginalization of the autistic community, these intersectional identities must be taken in consideration. Whether it is autistic adults of low socioeconomic status who are deprived of access to private services, autistic adults who reside in the periphery of Israel and have no services available nearby and have to travel for hours to access services, Arabic autistic adults who do not have services or professionals who speak their mother tongue, Ultraorthodox autistic adults who do not have professionals who understand their cultural nuances, or women with autism who find themselves alone with no supporting services in the struggle to achieve their “desired” Israeli family, all are important to fully understand the inequalities faced by autistic adults in the Israeli context. Although the analysis of the survey findings did not produce any statistically significant results and thus did not fully support the qualitative findings in relation to the marginalization of certain intersectional social groups, they did not refute them either. These findings stress the need for future quantitative research to explore the question of inequalities among autistic adults in Israel. From the perspective of SDHs, this section established that the social position of autistic individuals in the Israeli context cannot be understood as a single social position. Multifaceted observation is essential to capture the extent of the marginalization autistic adults in Israel suffer from. Any intervention to improve the wellbeing of autistic adults must take these findings into consideration and try to introduce services that will also be directed at reducing inequalities among autistic individuals.

## 6.2. The causes of inequalities

Having established that there is discrimination against certain groups of autistic adults, the next step on the long journey to reduce inequalities is to understand the mechanisms that contribute to these inequalities. This section opens with a depiction and analysis of the autistic groups that are identified in the political arena as being marginalized. This examination illustrates how some groups, including Ultraorthodox autistic adults and autistic women, are left out of this conversation. It also shows that the discourse around inequalities deals exclusively with existing services, disregarding inequalities that arise from unregulated issues altogether, which unfortunately, as the previous chapter illustrated, are all too common. Then, the section turns to explore the reasons assigned to the inequalities. Three main explanations appeared to be central among stakeholders. The first explanation asserts that inequalities are not an autism-related issue. Common forms of discrimination, whether they are based on socioeconomic status, place of residency, or ethnic group, extend to those with autism and contribute to inequalities among autistic adults. This population is affected just like any other group in society by existing inequalities (Filc, 2009). The second explanation asserts that the reason for not developing services for certain groups of autistic adults is the result of a low demand for the services. This approach proclaims that inequalities among adults are merely a projection of inequalities in diagnosis and recognition among children. According to this line of thought, to tackle inequalities in adulthood efforts should be concentrated on early diagnosis and intervention. Lastly, cultural explanations, in the form of a lack of awareness, are sometimes given as a cause of inequalities, mainly between ethnic or cultural groups and usually in regard to disparities in diagnosis. In addition to discussing each of these three discourses regarding inequalities among autistic adults in Israel, this section analyzes their limits and argues that they constrain the ability of individuals to discuss structural and political discrimination and discourage participants from marginalized groups from participating in the discussion. The section ends by claiming that the demand-oriented rationale for establishing services, which is the core of the three discourses outlined above, is itself a discriminatory practice that contributes to inequalities among autistic individuals.

### 6.2.1. Inequalities in the political arena

Most of the inequalities among autistic adults described above, despite their novelty in the scientific literature, will not come as a surprise to anyone involved in the autism policy field. For years, inequalities in access to services have been reported to the various relevant parliament committees and appeared in ministerial documents. Inequalities among individuals from different socioeconomic backgrounds, inequalities according to geographical proximity to the center of the country, and inequalities between Jews and Arab have been recognized by diverse official bodies. In the following section, official documents are analyzed, and the argument is made that certain groups and issues are still absent from official discourses. It is further argued that these official discourses neglect the influential implications of SDHIs, which are not ground in policy.

The issue of inequalities among autistic individuals from different socioeconomic classes in Israel is well known to government and public officials. The most indisputable example, although it is related to autistic children, appears in the Israeli state comptroller report form 2017 who reviewed the provision of therapies for developmental disorders. In the report, the MoH is criticized for allowing therapies to be offered by private providers if the waiting lists for public services are too long. The comptroller writes: “This approach raises several fundamental issues […]; creating ‘medical services for the rich’ – children who were born to families that had good financial fortune could get services they need early, while others will not.” (Comptroller annual report 2017: Treatments in child development area, 2017 p. 384). In addition to putting the issue of inequalities among autistic individuals on the table, this example illustrates that in the absence of public services a private market can flourish, creating inequalities among autistic individuals based on socioeconomic status and leaving those who are less fortunate economically without any services.

Another example of how socioeconomic status can directly influence the wellbeing of autistic adults is the entry and monthly fees that must be paid to live in state funded institutions – houses for life ("בתים לחיים"). In 1999, in a hearing at the Labor, Social Service, and Health parliament committee dealing with an eligible abuse in a residence for autistic adults, Ilan Gilon, a Knesset and a committee member, queried: “on which kind of institute we are talking about? A private institute? A private institute under [state] supervision? I read here [a newspaper article about the case] that the parents need to pay 35,000 dollars [as entry fees], and then every month”. Doctor Dalia Gilboa, from the MoH, replied: “They [the organizations that open institutions] got assistance from the Ministry of Health and other ministries […] and the Ministry of Health also provide monthly support, there was a necessity, unfortunately, that parents will also participate.” (Suspicion for abuse at “Kfar Shimon” an institution for autistics, 1999). Dr. Gilboa, in her answer, explained to the Knesset member that the institution was a publicly funded institution that needed to take money from parents for its establishment and continued operation. Despite this unfortunate situation having changed over the years, as I will show in the next chapter this is still an accepted practice that results in inequalities among autistic adults based on their economic status. The Knesset member’s confusion can be understood, as publicly funded services do not usually require the “need to be very rich”, as he put it during the same hearing.

The issue of inequalities among autistic individuals according to their residential location – center or periphery – was also raised in public documents. In a report written by representatives from the Labor and Social Services (MOLSA’s previous title) and the Ministry of Health back in 1993, following a decision to develop a joint comprehensive plan to address the needs of autistic individuals in Israel, the authors recognized disparities in services between the center and the northern and southern peripheries of Israel and stated: “It should be noted that the most of the services exist are located at the center of Israel. The north and the south areas are very poor in needed services.” (Gilboa, Aminadav, & Elishar, 1993). The report was based on a survey carried out that year, which illustrated the gaps and clearly stated that the services in both these peripheral districts were not developed.

This was not the last time geographical inequalities were mentioned in official government documents. Recently, a meeting of a special parliament sub-committee of the Labor, Social Services, and Health parliament committee was convened to draft a program to manage autism in the Arab minority population (The establishment of a sub-committee on the topic of autism in the Arab minority, 2018). Many participants mentioned the gaps in services for autistic individuals who reside in Israel’s periphery and specifically in the Southern District. Bella Ben Gershon, the head of the Autism Department at the MoH, regarding the shortage of professionals, said: “But we all know, in all professions, in all professions also in the Jewish sector, we have severe shortage in the peripheral areas, especially in the south.” (Data and overview of the autism phenomenon in the Arab sector, 2018). Ms. Ben Gershon’s comment echoes the lack of professionals in the periphery that was raised by the interviewees. Her comment also demonstrates that government officials recognize the different axes of autistic individuals’ social position when they have to assign a cause of the unacceptable disparities. In this case, in a hearing about the gaps between Jews and the Arab minority, the official position was that the finger of accusation should be pointed toward geographical disparities not ethnic disparities, minimizing the latter as irrelevant. This example illustrates the importance of performing a multidimensional analysis of the social position of autistic individuals, as the reduction of an analysis to certain axes of this social position might obscure other, discriminatory dimensions.

Another important issue with regard to geographical inequalities that was not discussed by interviewees was raised by Dr. Gal Meiri, the head of psychiatric services for preschoolers at Soroka Medical Center, the only medical center in the Negev area in the south of Israel. At the same meeting in which Ms. Ben Gershon participated, he pointed to an additional injustice the uneven geographical distribution is causing in the Israeli context: “The same taxpayer, a parent, can pay taxes in order a child from Ra’anana[[9]](#footnote-9) will receive all the services needed and a child from Be’er Sheva[[10]](#footnote-10) or a child from Rahat[[11]](#footnote-11) will get less” (Data and overview of the autism phenomenon in the Arab sector, 2018). Dr. Meiri is using the example of geographical inequalities to explain how inequalities in a universal public system, where taxes are centralized and services are provided by the government, results in an uneven distribution of services that is unjust and discriminatory. In the Israeli context, which includes a public healthcare system, autistic individuals who reside in the periphery are discriminated against not only because they have reduced access to services, as described above, but also because an absolute uneven distribution of resources that is collected eligibly equally. This argument also holds true for other dimensions of discrimination.

Considering that the sub-committee in which Ms. Ben Gershon and Dr. Meiri participated discussed the Arab minority, it is unsurprising that inequalities between autistic Arabs and Jews was also known to the relevant ministries. As long ago as 2012, gaps in the diagnosis of autistic Arab children were raised by the Israeli state comptroller, pointing to the small number of children who are diagnosed with autism among the Bedouin community in the Negev (Comptroller annual report, 2012 p.921). This finding was highlighted again in the scientific literature, as shown in a literature review conducted by Kerub and colleagues (2021). Recently, in the hearing mentioned above, the testimony of numerous professionals included references to inequalities among Jews and Arabs across Israel. Nida Abu-Ahmad, a speech therapist and the manager of a center for children with autism, mentioned “the total shortage in diagnosticians and paramedical professionals that speaks Arabic […] and the small scale of support provided for parents and families by knowledgeable professionals as psychologists and social workers” (Data and overview of the autism phenomenon in the Arab sector, 2018). Ms. Abu-Ahmad’s emphasis on the the lack of language and culturally competent therapists corresponded with the point made earlier by Gefen. However, the claims raised by Rafat Ayashi, a social worker and the coordinator for the Arab community in Alut, the largest organization for parents of autistic individuals in Israel, were the most relevant for adults with autism:

“I think that the ministry of social services should be prepared for a situation in which in few years there will be requests from adults with autism that don’t have any employment solutions that are suitable […] compatibility is also needed in academic programs in colleges and universities in terms of culture and language for those who are high functioning […] there is also a great shortage in leisure options, in all the Arab society there is only one afternoon facility for adults that began to operate in the north a year ago”. (Data and overview of the autism phenomenon in the Arab sector, 2018.)

Mr. Ayashi points to numerous shortages in the services available for autistic adults from the Arab minority, from shortages in employment placements to an absence of academic programs as well as a lack of facilities for afternoon activities. In addition to the physical shortages, he stresses the issue of suitability and compatibility of the services provided both in academia and employment and refers to “high functioning” autistic adults from the Arab community who are usually overlooked. The observations made by Mr. Ayashi and Ms. Abu-Ahmad emphasizing the discrimination against the intersectional identity of Arab autistic adults in the Israeli context are also recognized by the authorities.

Although discrimination against individuals from several sectors of society was mentioned in official records or by the interviewees, some sectors who are considered discriminated against in the Israeli context were not raised. Jewish immigrants, especially those from the Ethiopian community and who are known to be discriminated against by the healthcare system, were not mentioned, either in the interviews or in any official records (Kaplan & Salamon, 2004; Jaffe et al., 2016); Mizrahi Jews (Jews of Arab/North African/Asian origin) were not mentioned in any of the official records or the interviews, despite being discriminated against in the Israeli context (Chetrit, 2009), including by the mental healthcare system (Nakash et al., 2014); and non-Jewish immigrants residing in Israel, who suffer from multiple marginalities, were not mentioned either (Filc, 2009 p.100-127). The absence of these communities from the analysis above should not be interpreted as meaning discrimination against them does not exist, but as bias in representation, both among the interviewees and in official forums. These groups should be further examined in future studies, as the discrimination against them is apparently not currently evident within the autism community or official bodies.

Some gaps were also identified between the inequalities raised by interviewees and those that appeared in governmental and parliamentary documents. The discussion within official bodies regarding inequalities is important; however, there was no recognition of the discrimination faced by Ultraorthodox autistic adults; gender inequalities, specifically the marginalization of autistic women and autistic adults from the LGBTQ community; and inequalities according to “functionality”. While the last of these is controversial, discrimination based on religiosity and gender was apparent in the research. It is important to recognize this discrepancy because it highlights areas that should be addressed in the future, both by the authorities and the autistic community.

Another gap that is apparent to the careful observer is that in the case of autistic adults there was no recognition of disparities in the healthcare system. In children, the absence of professionals was mentioned in the context of socioeconomic, geographical, and ethnic disparities; in adults, however, the issues that were mentioned were all related to SDHs, such as residential arrangements or employment opportunities. It is crucial to pinpoint this gap between the research findings and official documents, as it signifies how and when the issue of inequalities is regarded and analyzed by authorities. Only when there is a policy in place do officials begin to discuss inequalities; nevertheless, as this section illustrates, in cases where there is no policy is place inequalities can be even more apparent and discrimination against sub-groups of the population can be exacerbated. Leaving the battle against inequalities until after policies have been established overlooks inequalities that are created in their absence. The conjoined approach this research offers is an understanding of SDHIs while applying an intersectional analysis, which might enable the development of policies that combat inequalities, even if those inequalities are not formally recognized and measured. In the case of autism such an approach is crucial, as any policy regarding autistic adults that disregards the inequalities described above will simply widen the gaps among autistic groups.

### 6.2.2. Is discrimination against autistic individuals so special?

After examining the depiction of inequalities in the political arena, the following analysis is focused on the main discourses raised by the interviewees, and by stakeholders in official documents, regarding the reasons for these inequalities. One of the explanations given by some interviewees for the inequalities among autistic adults is that they mirror general inequalities in society. This reasoning asserts that discrimination is transferred from one social field to another. For instance, inequalities in healthcare service provision between the center and periphery that are known to be a problem in Israel (Avarbuh, Perez, Idelman, Avni, Greenbaum-Arizon, 2021) are also causing inequalities in service provision for autistic adults. Geula, who holds a senior position in the MoH and who is responsible for, among other things, autism, expressed this position when asked for her take on the factors affecting inequalities:

“At the population in general, the issue of periphery is a known issue, it does not matter from which direction. Or [whether it] one sectors or the other that are known as sectors that [need] more investments and devotion. There is nothing special here.” (Geula, who holds a senior position in the MoH.)

The perspective Geula presented regarding services for autistic individuals is that this is “business as usual”, that nothing is unique about their case. Inequalities between the center and the periphery are a known phenomenon that affects “every direction”, referring to other services provided by the MoH that also exhibit disparities according to geographical location. Her additional note regarding the sectors that are discriminated against implies that, although she recognizes additional resources are needed to resolve inequalities in the case of autism, because it is not an exclusively autistic issue it should not further explored. Bat-El, an advocacy lawyer who works with the autism community, extended the argument further and claimed: “you know all over the world there are disparities between center and periphery, we did not invent anything” (Bat-El, an advocacy lawyer), again pointing to autism as being just another case of inequality. These broad arguments that declare inequalities among autistic adults to be just another manifestation of known inequalities shift the focus from the intersectional social position of autistic adults to one specific dimension of discrimination, leaving autism out. By doing so, this argument misses the unique manifestations of the social position of autism that is under scrutiny, for better or worse.

This reasoning of inequalities is not always presented as a broad argument, however. A more subtle presentation of this argument was raised, for example by Ben, the director of a program focused on autistic adults, who said in his interview:

“I don’t know how familiar you are with family physicians here in the north. I have a lot of friends who just finished their degree in medicine, and they are shocked from the services we are getting here. The services here in the north are not good, even if you are a neurotypical.” (Ben, a professional working with autistic adults.)

In a conversation regarding medical services for autistic adults, Ben stressed that regardless of whether one has autism, the quality of medical services in the periphery is poor. Speaking from his own experience, he simply argued that autistic individuals suffer from disparities in medical services in the same way as anyone else who resides in the periphery. Although this argument might be true, it again fails to take in consideration the uniqueness of the autism case. Ben himself, in a different part of his interview, pointed to the benefits that the periphery might have over the center for autistic adults, for example, in terms of the acceptance of people with disabilities. Such observations are needed to capture the complex picture of discrimination. Despite this critic, it must be considered that in a discriminatory context it could be harder to identify differences in discrimination. On the micro level from which Ben is departing it might be harder to distinguish one bad service from a second worst service. To conclude, the “it is all the same” argument trivializes the complexity of discrimination against the autistic intersectional social position, which is covered above.

### 6.2.3. Blaming diagnosis: No autistics = no services

The second explanation that was dominant, both among interviewees and in official documents, is that the gaps in services for autistic adults from certain sectors of society are a consequence of the limited number of autistic individuals diagnosed from those sectors. Simply put, the proponents of this explanation argue that when there are not enough participants, there is no demand, and thus there is no rationale to develop services. Services for autistic women are underdeveloped according to this rationale, as discussed above, because there is underdiagnosis of women; similarly, there is a shortage of services for autistic adults from the Arab community because too few individuals with autism from this community are diagnosed. The same is true of certain services in the periphery of the country.

This explanation, which has been adopted by many of the stakeholders, is the result of an administrative decision made by MOLSA. Sarit Alovitch Levi, the head of the Evaluation and Recognition Service at the Disability Administration at MOLSA, described this decision during a discussion of the shortages of services for the Arab community: “It is important to say that we are developing services and assistances according to the issue of demand. That is so to say the moment that we see a demand and a need we develop the service” (Data and overview of the autism phenomenon in the Arab sector, 2018). The rationale as presented by Ms. Alovitch Levi is a market-like rationale: if there is no demand, services will not be developed. The comptroller’s report from 2012 clarifies what Ms. Alovitch Levi means in practice, when discussing residential arrangements for autistic individuals: “when there is no suitable placements in the existing hostels [residential homes] and several individuals with the same needs are assembled in the waiting lists the ministry publish a tender to open a new suitable residential facility” (Comptroller annual report, 2012 p.930).

The drawback of this policy decision in the case of autism is that it reproduces inequalities that already exist among autistic children. As the literature review demonstrated, there are serious gaps among different social groups at the recognition phase. Establishing services according to a numerical rationale replicates, even if unintentionally, the marginalization of these social groups in adulthood. In addition, as explored in the previous chapter, a publicly funded diagnosis of autism in adulthood is not available, leaving adults from discriminated-against groups with no option but to wait for additional autistic children who have the same needs as them to grow up. However, as the comptroller’s report described, the discrimination does not end there. The need to establish, for instance, a residential facility in haste “forces the operator to propose a temporal place that had been shifted in short period to the needs of autistics. Not once the operators need to change the temporal building and transfer the residents while damaging their quality of life.” (Comptroller annual report, 2012 p.930). The comptroller’s report notes that not only do autistic adults from marginalized groups need to wait until services that are suited to their needs are established but also that when they are established, due to current administrative decisions, they are not properly suited for their needs and may further harm their quality of life.

Several interviewees also described the gaps in services among autistic groups using this rationale. However, accepting this neoliberal, market-oriented perspective on the development of social services was often coupled with criticism. Gefen, for instance, the mother of an autistic adult and an activist in the field of autism, mentioned the difficulties in establishing social groups:

“It is very very difficult also because simply the number of people [autistic individuals] is much smaller [in the periphery]. If you open a group in Tel Aviv,[[12]](#footnote-12) you have no problem to fill it. If you open a group in Nahariyya, or Netiv HaShayara, or Shlomi, or Beit HaEmek [cities and villages in the north of Israel] it is very complicated to find enough [adults] to establish this group […] and we did no succussed forming this group again [after it was canceled …] the small secluded and distanced settlements, horrible public transportation […] in some of the places you either do not have any public transportation or a bus once a day, this is not something you can work with.” (Gefen, the mother of an autistic adult and an activist.)

Speaking from her experience with her son, Gefen described the actual difficulties in not having enough candidates to form a social group. Comparing several cities in the north to Tel Aviv, she expressed her frustration with the under-recognition of autistic individuals in the periphery that de facto prevented her son from obtaining the services he needed. Although Gefen’s example illustrates the damage that can result from the disparities in diagnosis, it explains inequalities using the same rationale the MOLSA representative described: not enough participants equals no services. Gefen, however, even if not intentionally, challenged this argument by pointing to the structural and geographical uniqueness of the periphery as a barrier to services. Turning the spotlight from the number of participants on to travel limitations, she broadened the borders of the periphery to such an extent that the demand constraint could be lifted. This type of solution demands additional funds, collaborations between municipalities and local authorities, and the demolishing of boundaries between social services and health districts. All of these are difficult; nevertheless, they have the potential to reduce inequalities that are rooted in the uneven distribution of diagnosis across the country. More importantly in the context of this section, it illustrates that the neoliberal rationale of demand depends on the definition of the “product”, of the service. This perspective is important, as it places the responsibility for the discrimination back on the managing authority that must define the service so it will be suitable for the needs, instead of waiting for the demand.

Shai, a professional who works with the Arab autistic community, also justified the limited service for this community based on the small number of Arabs diagnosed with autism. However, after declaring that he “understands” this rationale, he criticized the demand-driven policy from another angle:

“The challenge is to be prepared to what will happen five years from now, this is the right line of thought […] thinking ahead of the future is what needed”

In a later segment of his interview, he further added:

“Is the system not doing enough and is it comfortable with the situation that only small percentage [of autistic individuals] approach, question mark? [My] Assumption, yes. An assumption. And then you need to deal with why yes or why not, ok? Is the Arab society the one who need to have more initiative to get services? that’s for sure.” (Shai, a professional who works with the Arab community.)

Criticizing the demand-oriented policy, Shai’s first quote above identifies the passive approach of the ministry and argues that the authorities should plan for future years. This approach is in opposition to that which suggests that the development of services should be left to autistic individuals or their families’ demands. This will require the system reaching out to the autistic community and filling any gaps they have identified in the services available. Being very cautious not to be too judgmental, in the second quote above Shai expressed harsh criticism of MOLSA, claiming that this situation in which the responsibility for developing services is transferred to the community is desired by the ministry. Shai explained it is desirable as it allows the authorities to shift the question on the causes of unmatched needs and inequalities away from them and back to the community. In other words, demand-driven service development is allowing the question to be focused on the demand side of the equation instead of the supply and asking “why yes or why not” people are demanding services.

To sum up, the second explanation for the underdevelopment of services for discriminated-against autistic social groups is that there are too few individuals from these groups to utilize such services. This explanation, in addition to replicating inequalities from childhood diagnosis and harming the quality of services, shifts the focus from the authorities, the supply side, to the receiving side. Whether or not this approach is more convenient to the authorities than simply planning ahead, it limits the discussion around inequalities. Most importantly, it does not allow a careful examination of alternatives that would expand the pool of service recipients and thus create demand.

### 6.2.4. Lack of awareness

Similar to Shai, cited above, who ended his quote by asking “Is the Arab society the one who need to have more initiative to get services?” and answering “that’s for sure.” (Shai, a professional who works with the Arab community), in a demand-driven system many ask this question and answer in the same manner. In an attempt to enhance demand, a follow-up question asked: “What is causing this low initiative?” Many stakeholders and interviewees, among them advocates, answered this question in the same manner, attributing the low demand for services among disadvantaged sectors to their low awareness or lack of knowledge about such services. Sarit Alovitch Levi, the head of the Evaluation and Recognition Service at the Disability Administration, who is cited above, represented the government perspective:

“There is an issue of *lack of awareness* and lack of service usage in certain sectors including the Muslim sector. […] despite we see an increase in awareness over the years there is still a gap comparing to high socioeconomic clusters […] there is a higher rates of Muslims that do not use services and also among Jewish population from African descent, Ethiopia, the USSR and alike” (Data and overview of the autism phenomenon in the Arab sector, 2018) [emphasis by the writer].

Starting with the issue of awareness, the MOLSA representative in this quote links the underusage of services to a lack of awareness among the underserved populations. While citing the conclusion of a report published by the Myers-JDC-Brookdale Institute on service provision for people with cognitive disabilities (Leff & Rivkin, 2015), she assembles in one basket several sectors that are underserved by the ministry and argues it is the lack of awareness that marginalizes them in comparison with higher socioeconomic groups. On top of being reductionist, as her argument overlooks the distinct mechanism of oppression each underserved community is subjected to, this generalization reveals how adjustable and compelling this argument is, in the context of demand-driven services. Gefen, who was one of the interviewees who critiqued demand-driven services from her perspective as an activist, also expressed similar ideas:

“I don’t know if to call it mentality, or culture, or culture of unawareness to services and consumption of services, passivity, I don’t know exactly how to call it, but also when you have parents […] or when you already have several people on the spectrum, it is hard to get them come and use the services and take […] to demand, to advocate for, to look for, to discover that there are treatments and demand it […] It could be that they are not familiar with, that it is bad experience they had in the past that resulted in mistrust.” (Gefen, the mother of an autistic adult and an activist.)

Adopting the perspective of officials, this mother–activist voiced her disappointment in those she is advocating for. Even in cases when the small number of recognized autistic individuals is resolved, the “mentality” of those residing in the periphery is restricting their ability to demand services. Although not exactly sure how to describe the reasons for this behavior, Gefen claimed being unknowledgeable or having little to no initiative makes it practically impossible for these individuals to demand services. The difficulty in describing the reason for not approaching authorities and her choice to classify it as “culture” is not accidental and appeared repeatedly during the interviews. For instance, Geula, who holds a senior position in the MoH and is quoted above, said when discussing the issue of inequalities: “no it is not an issue of language, it is an issue of community, a sector […] this is also a cultural issue […] Yes cultural differences, yes” (Geula, who holds a senior position in the MoH). While this reasoning is grounded in some factual basis, such as the example Calanit, the mother of an autistic adult and an activist, mentioned in her interview regarding the Ultraorthodox community, who avoid diagnosis from a “fear on the chances of matchmaking of the brothers and sisters” (Calanit, the mother of an autistic adult and an activist)[[13]](#footnote-13), it acts as tool to transfer the obligation away from the privileged majority in two ways. First, as mentioned earlier, by shifting the pendulum back to the service recipients and claiming that the problem is with those who are not demanding services, rather the problem of the authorities; and second, by masking the context in which this demand-oriented policy has been constructed - the “culture” of the majority, the hegemony. This culture, which sets the social spatial agreements, the context, is concealed from this discussion and thus not subjected to criticism.

A glimpse of this criticism, however, can be understood from Gefen’s quote. Gefen ended by saying that, with regard to individuals and families from the periphery of Israel, that: “It could be that […] it is bad experience they had in the past that resulted in mistrust” (Gefen, the mother of an autistic adult and an activist). Referring to two related yet separate issues, bad experiences and mistrust, Gefen hypothesized that the unwillingness to demand services is a result of these two factors. Indeed, negative experiences could evoke mistrust, but mistrust between privileged and disadvantaged sectors is a much more complex issue, as Hermesh (2020) describes in his dissertation in regard to mistrust between the Bedouin in the Negev and the establishment. The relationship between trust and the utilization of services is not within the scope of this current dissertation; however, Gefen’s point stresses that the culturalist argument, which includes the awareness reasoning for inequalities, is limiting the discussion, for example about the trust and mistrust between authorities and discriminated-against minorities.

The consequences of limiting the discussion on inequalities to the issues of diagnosis and awareness exceeds beyond the borders of the discourse itself. It affects the willingness of the discriminated populations to participate in such discussions and it also diverts investments to solutions which correspond with this reasoning. Shai, a professional who works with the Arab community, quoted above, expresses in a different part of the interview his discontent with the focus placed on limited awareness of autism as a reason for inequalities:

“No matter where you are going a committee, a discussion, with professionals from the Jewish society that want to talk about autism in the Arab society […] when interviewed to the radio, what do they want to hear and deal with from their subjective perspective? The Arab [society] is a traditional is an unconstructive […] is a shameful of its [autistic] children […]. Because apart from professionals who live the Arab society [in their] day to day and are familiar with the situation that the Arab society of 2018 is not the same as a 100 years ago [… all others think it is] shamefulness and segregated […] when I am conducting a discussion it annoys me to deal with this issue.” (Shai, a professional who works with the Arab community.)

The “lack of awareness” argument is presented by Shai as a stigmatizing act that identifies Arab society as being anachronistic and underdeveloped. According to him, arguing that the inequalities among Jewish and Arab autistic individuals are the result of a cultural differences signifies the subjective Jewish perspective of Arab society. Speaking from his experience of practice within the Arab community, Shai is “annoyed” that every discussion on the subject returns to those questions, which for him are prejudiced and not based on grounded experiences. It is crucial to note that his observation does not concern people who disregard inequalities among autistic Jews and Arabs altogether; on the contrary, he points to professionals who do want to deal with this problem. The eligible partners who aspire for equality are the ones that discourage him from participating in this discussion due to their focus on their prejudice prejudgment of the Arab society. More broadly, Shai presented this argument as a counterproductive one, that not only limits the discussion but discourages the oppressed community from participating in it.

It is worth mentioning that the argument of awareness was also raised by individuals from the Arab community. For instance, Nida Abu-Ahmad, an Arab professional who was mentioned earlier as pointing to the issue of a lack of professionals in Arab society, pointed out the same Knesset discussion on the problems of autism in the Negev, that: “lack of awareness of the Arab population to the subject of autism” is one of the issues (Data and overview of the autism phenomenon in the Arab sector, 2018). Thus, to claim that awareness as a cause of inequality is just an argument made by the Jewish majority would be incorrect. As mentioned earlier regarding the Ultraorthodox community, this argument is grounded somewhat by actual findings; however, it might create a problem if it were to take over the whole discussion and block possible criticism on the masked culture of the majority.

The second consequence of adopting the rationale that a lack of awareness is the cause of disparities among autistic individuals from different sectors of society is that it diverts resources to projects that focus simply on raising awareness. For instance, Inbal, a professional consultant for autistic adults and previously the manager of a residential facility for autistic adults, described her experience with efforts to increase awareness:

“Really few are approaching us, some are but really really few. I think it is because of language barrier and the… awareness. I know the people that work intensively [with] the Arabs [communities] on the issue of awareness […], they go to Tipot Halav[[14]](#footnote-14), I also arranged a seminar in Jerusalem, east Jerusalem, but it is more directed currently to children. For adults there is much less awareness”. (Inbal, a professional consultant for autistic adults and previously the manager of a residential facility for autistic adults.)

Despite depicting two barriers to accessing services, language and awareness, Inbal described only the efforts of officials to increase awareness among the Arab community. Language barriers, which clearly limit the access of autistic individuals and their families from the Arab and other minorities, are not being “intensively” addressed. Sivan’s quote also makes a link between the two rationales used to explain inequality in a demand-oriented system, i.e., the lack of diagnosis and the lack of awareness. She highlights that even though activities to increase awareness are prevalent, these are focused on children to expand awareness for diagnosis, leaving autistic adults from disadvantaged communities lacking even this intervention.

To sum up, the lack of awareness argument is widely used to explain inequalities among autistic individuals. Although this argument is also extensively made in discussions around general inequalities in the healthcare system in Israel (Avni, 2016), in this specific case it has several implications. It maintains the spotlight on the recipient side of the service and limits the discussion of the supplier, the authority side. It prevents any examination of the reciprocal relationship between the minority and the hegemonic cultures; thus, it misses cardinal factors such as mistrust. It causes those from underprivileged communities to avoid discussions around inequalities. Finally, it diverts efforts to awareness projects instead of other factors that contribute to marginalization. The great focus on this argument mandate reckoning of stakeholders given its negative implications.

### 6.2.5. The establishment of demand-driven services is a catalyst of inequalities

As mentioned above, both the diagnosis and the awareness arguments are products of the establishment of demand-driven services, the result of a decision made by the MOLSA. In this part of this section, following the drawbacks of these arguments outlined in the analysis above, I argue that it is the administrative decision to establish services according to demand that contributes to the inequalities observed among autistic adults. It does so indirectly by covering the system responsibility, as discussed above, and directly because both in the case of marginalized communities where stigma is a factor that prevents access to services (Ben-Zeev, Corrigan, Britt & Langford, 2012; Han, Scior, Avramides & Crane, 2021; Rüsch et al., 2018) and in autism itself where self-advocacy is a barrier, this demand-driven administrative decision results in lower utilization of services.

As the previous parts of this section demonstrated, the greatest damage resulting from shifting the discussion to the service recipients and masking the context in which policy decisions are being made is that it limits the discussion around inequalities. Shai, a professional who works with the Arab community and who is quoted above, summarized this damage very evocatively when he talked in his interview about the diagnosis argument as a cause of inequalities:

“I am telling you, great wonderful, this is wonderful data [that shows expansion of diagnosis among the Arab society over the years], but this is a preface. For me it is just a preface of the discussion, like an introduction of [an academic] paper. I want results, data analysis, discussion, conclusions. That is what I want and those are the things that they are dealing with the least. Do you know why? Because there are things that are not solvable.” (Shai, a professional who works with the Arab community.)

The discussion around inequalities, as Shai described it, is narrow and deals almost exclusively with the “preface” of the problem. The introduction to the reasons for inequalities until the point of diagnosis is comprehensively addressed, but Shai is frustrated that inequalities in all of the following steps in an autistic individual’s life, from childhood interventions to adulthood, are largely ignored. Put differently, the diversion of the discussion around inequalities in a demand-oriented system onto aspects relating to the potential beneficiaries reframes the discussion and restricts it to the reasons for limited diagnosis and limited awareness. Nevertheless, Shai does not finish his observation there, he ends by saying that other reasons for inequalities “are not solvable”. In addition to expressing discouragement, his use of this phrase refers to the unwillingness of the partners engaged in this discussion, including professionals, government officials, and some activists, as shown above, to solve inequalities by starting to open the Pandora’s box of reasons underlying these inequalities.

The second mechanism by which a demand-driven service affects inequalities is by directly erecting a barrier to services for autistic individuals and specifically those from marginalized communities. Ronen Gil, an autistic advocate, explained in his interview very accurately the relationship between the need for active engagement by authorities, as opposed to demand-driven services, with autistic individuals and other disadvantaged communities, to help these communities access services:

“This is something [reaching out to the community] that is not part of their [MOLSA’s] worldview. And this is the first thing needed specially to treat autistics properly. Because of all the stigma and stereotypes and […] communication with autistics. The first thing that is needed is to reach out […]. And it is not concerning only autistics. It is not only concern people with disabilities either. It concerns women, women suffering from violence […], drug users […], Arabs, it concerns any disadvantage community in the society. Until you won’t do an active reach out you won’t reach to fundamental positive change”. (Ronen Gil, an autistic advocate.)

Starting by setting out the baseline to his argument that the governmental policy is a demand-driven one, an argument that had been mentioned in an earlier segment of his interview, Ronen explained that to address the needs of autistic individuals, active outreach by the authorities is essential. He argued that in the case of autism, stigma, stereotypes, and communication differences limit the ability of autistic individuals to demand services and to self-advocate, as mentioned in chapter 4. Thus, his argument in effect turns the tables and claims that this administrative decision, in the case of autism, is socially disabling, that it itself is a barrier, or in other words further marginalizes this population. Broadening the scope of his claim further to include other underserved communities allows an additional perspective on the creation of inequalities among autistic adults in a demand-driven system. According to Ronen, marginalized groups in society avoid demanding services because of stigmatization and the stereotypes attached to both their marginalized position and to the social services they need. Autistic individuals from these groups thus avoid demanding services not just on the grounds of being autistic but also because of their additional marginalized identity. This stigmatization serves as another barrier between these intersectional social positions and the services they require. Autistic women, for instance, need a system that will reach out to them, as Ronen concluded, otherwise they will avoid services not only because they are autistic but also because they are women in a patriarchal society that further stigmatizes them. It can be concluded, therefore, that a demand-driven service system is enhancing inequalities both by preventing a thorough discussion around the social constructs that fuel the marginalization of autistic adults from underprivileged communities and by dissuading those who are stigmatized and have difficulties in self-advocacy from reaching out for services, a process that further limits their ability to demand and use services. Put simply, a demand-driven approach to services is an SDHI in the Israeli context that affects all autistic individuals but especially those from marginalized communities.

To sum up, the discrepancies between the analysis of the interviews presented in the previous section and the analysis of official documents at the beginning of this section demonstrate that certain groups identified in the first analysis, including Ultraorthodox autistic individuals and autistic women, are not regarded as discriminated against in the latter analysis. More importantly, this illustrates that authorities will only seek to address inequalities once policies are in place. In cases where policy is absent yet inequalities exist, the issue is disregarded. This analysis demonstrated that the official struggle for equity lags behind reality both in regard to the intersectional social position it addresses and the issues it covers. The discourse analysis of the reasons for inequalities among autistic adults identified three main reasons assigned by interviewees and stakeholders: inequalities among autistic adults are an additional manifestation of social inequalities unrelated to autism; inequalities are a result of gaps in diagnosis that manifest in adulthood as there are too few participants to open services; and inequalities are the result of cultural reasons and specifically a lack of awareness among individuals from marginalized communities. While all three reasons can partially explain the inequalities observed, the analysis above demonstrates the various limitations of these explanations. First, these reasons overlook the specific context of inequalities and disregard the unique marginalization of the intersectional social position of autistic individuals from underprivileged communities. Second, they distance the discussion around inequalities away from the supply side, the executive authority. The direct effect of this is to assist the suppliers in avoiding a discussion on the nature of the services they provide and the additional causes of inequalities, including the context in which policies are created. The cultural-awareness argument masks the role of the hegemonic culture in creating inequalities and further stigmatizes the oppressed communities. The section finally argues that demand-driven services provision is at the root of the diagnosis and awareness arguments and that this in itself contributes to the creation of inequalities by diverting the discussion and by requiring autistic individuals who struggle with self-advocacy to demand services. In the following chapter, I will delve into one of the most undiscussed causes of inequalities among autistic adults, I will open the Pandora’s box stakeholders attempt to avoid and analyze the influence of parents’ organizations in the field of autism on inequalities among autistic individuals.

## 6.3 Conclusions

This chapter used the analytical framework of intersectionality, initially used to analyze the multidimensional identities of autistic adults in the Israeli context, to establish whether certain intersectional social positions are discriminated against. After demonstrating how certain groups within the autistic community are further marginalized and that these inequalities exist, the chapter turned to examine the discourses around the reasons for this discrimination. Together, the two sections further promote the understanding of autistic adults’ multifaceted marginalization in Israel and the causes of this unjust and harmful reality.

Being the first research, to my knowledge, to examine the question of inequalities among autistic adults in Israel, the chapter explored which groups within the marginalized autistic community are further discriminated against. Exploring one intersectional social position at a time, the first section demonstrated that autistic adults from low socioeconomic status, autistic adults from the geographical periphery of Israel, Arab autistic adults, Ultraorthodox autistic adults, and autistic women are all deprived of equal access to services. The main gaps reported by interviewees were gaps in available services for these groups and a severe lack of trained professionals who have suitable linguistic or cultural skills or specific acquaintance with the needs of intersectional autistic identities. The section also considered the unique manifestations of this marginalization in the Israeli context. Such manifestations include the consequences of the shortage of suitable services for autistic women in a pronatalist society and the implications for Arab autistic adults’ intersectional identity in a society that labels Arabs as a potential threat. Although the survey findings do not clearly support the qualitative insights, neither do they refute them, thus highlighting the need for future, quantitative examinations of this issue. Lastly, the section demonstrated that there is room to further scrutinize the multidimensional experience of autistic individuals as opposed to the bidimensional intersectional examination conducted.

Next, the formal recognition of inequalities among autistic adults in the political arena was analyzed. The analysis revealed that the marginalization of certain groups was absent from formal discussions and that these discussions were focused only on available policies, while avoiding the consequences of not having suitable policies on inequalities. These conclusions signify the need to reevaluate the discourse around inequalities in the case of autism, otherwise measures that are taken could not probably marginalization. In the quest to address inequalities their depiction is only the first step, thus the chapter next turned to analyze the discourses around the reasons for these inequalities. Three main discourses were identified. The first, which claims that the disparities between autistic groups is merely a reflection of known inequalities in society, fails to recognize the unique manifestations of the intersectional identities of autistic individuals. The second and third arguments, which are based on the rationale that stems from a demand-driven services construct, assert that services are not available because there are too few autistic individuals to utilize them and that the low rate of utilization is a result of limited awareness among autistic individuals and their families from marginalized communities. These arguments limit the discussion to the recipient side of service instead of considering alternatives on the supplier side, such as planning for the future or amending services so they are appropriate for a wider range of autistic individuals. In addition, these arguments replicate inequalities seen among autistic children, masking certain aspects of discriminatory practices, such as the effect of the hegemonic culture and stigmatizing marginalized communities as underdeveloped. The second section ends by arguing that the demand-driven rationale is discriminating in itself and contributes to inequalities. This approach to service, it is claimed, discourages discourse around inequalities and mandates autistic individuals, especially those from marginalized communities, to make demands for themselves in a stigmatizing, disabling society, disregarding the negative effects of stigmatization and autism on the ability of these individuals to self-advocate.

A multifaceted understanding of inequalities, this chapter argues, is necessary to understand the full ramifications of SDHIs for the autistic population in Israel. Neglecting this perspective, as unfortunately is often the case, not only restrains our abilities to understand how and where these inequalities have their effect and what would be the best strategy to address them so that all autistic individuals will benefit from such efforts but also limits our ability to analyze current discourses on the reasons for inequalities that are discriminatory and unfortunately overlook crucial aspects of marginalization. While the social position of autistic individuals is clearly affected by the disabling context of the Israeli society they live in, their experiences, especially of those autistic individuals from marginalized communities, cannot be reduced to this position alone, as the SDHIs shape the reality of different intersectional groups in diverse and discriminatory ways. Any attempts to reduce the impact of SDHIs must take into consideration the limitations of the current discourse around inequalities and continue to explore the mechanisms that create them. In the next chapter, I will delve into one of these mechanisms.

1. See Werner & Hochman, 2019, on the importance of the military in forming the identity of individuals who have an intellectual disability. [↑](#footnote-ref-1)
2. The “drought line” is an expression referring to the south district of Israel, of which a large proportion is desert. [↑](#footnote-ref-2)
3. The area between Hadera and Gedera, which are two cities at the borders of the Israeli center, is a phrase that is used to describe the extended center of Israel (Milog, 2021). [↑](#footnote-ref-3)
4. This context includes a lack of training for police officers to identify and properly address people with invisible disabilities (Kaplan, 2021) and profiling practices that discriminate against the Arab population in Israel (Whitaker, 2010). [↑](#footnote-ref-4)
5. Bnei Brak is a city in the center of Israel that is populated mainly by Ultraorthodox Jews (Malach & Cahaner, 2020, p.17). [↑](#footnote-ref-5)
6. Mayanei Hayeshua Medical Center is located in Bnei Brak and is dedicated for the community of the city. [↑](#footnote-ref-6)
7. The Hasydic dynasty of Gur (or “Ger”) is one of the largest ultraorthodox congregations (Brown, B., 2013). Being a Hasid means being a part of this congregation. [↑](#footnote-ref-7)
8. Cochav kept me updated on her familial status throughout my research. On the date of the publication of this work, Cochav was married and after receiving fertility treatments became the mother of a beautiful girl. She fulfilled her dream. [↑](#footnote-ref-8)
9. Ra’anana is a city located in the center of Israel, ranked 8 (where 1 is the lowest and 10 is the highest) in the socio-economic index value reported by the Central Bureau of Statistics (Central Bureau of Statistics Israel, 2017). [↑](#footnote-ref-9)
10. Be’er Sheva is the largest city located in the south of Israel, ranked 5 in the socio-economic index value reported by the Central Bureau of Statistics (Central Bureau of Statistics Israel, 2017). [↑](#footnote-ref-10)
11. Rahat is a Bedouin city located in the south of Israel, ranked 1 in the socio-economic index value reported by the Central Bureau of Statistics (Central Bureau of Statistics Israel, 2017). [↑](#footnote-ref-11)
12. Tel Aviv is the most populated city in the Tel-Aviv and central districts of Israel (Central Bureau of Statistics Israel, 2019) [↑](#footnote-ref-12)
13. See Greenberg & Witztum, 2013, on the challenges of matches for marriage in Ultraorthodox individuals with mental health issues. [↑](#footnote-ref-13)
14. Tipot Halav are mother and child healthcare clinics operating in Israel (Rubin et al., 2017). [↑](#footnote-ref-14)