The Israeli Law for the Rehabilitation in the Community of Persons with Psychiatric Disabilities: Achievements and Challenges[[1]](#footnote-1)

Abstract

The Community Rehabilitation of Persons with Mental Health Disability Law (2000) is one of Israel’s most important pieces of social legislation. It grants people with psychiatric disabilities the right to receive rehabilitation in the community, including a number of rehabilitation services provided according to a professional decision while still taking the individual’s own wishes into account. This law has become a significant driver of major change in Israel’s mental health services. This paper is a case study of the development and implementation of a policy that led to the rehabilitation reform and that has become an important component in Israel’s comprehensive mental health reform. The paper also seeks to illustrate the issues facing social reforms in general while addressing the vision and the reality associated with substantial policy changes in social services. The first part of the paper describes the law, analyzing its implementation in the first two decades following its enactment and the second part focuses on what is needed for its continued application and enhancement as the third decade of its implementation proceeds.

**Purpose**: To review and analyze the law and its elements, examine its implementation during its first two decades of operation, and to identify the issues it faces entering its third decade of application.

**Method**: The study examined the key components of the reform and its implementation, focusing on the target population and the changes occurring within it, the budget allocated to the field, the workforce implementing it, the services provided under it, and the challenges the reform has faced.

The study used official statistical data received from Israel’s Ministry of Health, the Central Bureau of Statistics, and the National Insurance Institute and also drew upon a series of interviews with professionals and policymakers in the fields of mental health and rehabilitation and other areas of social welfare related to community rehabilitation.

**Findings:** In 2020, 30,000 people were receiving community rehabilitation services, constituting about one fifth of the estimated eligible population (aged 18+). Together with their families, who are also entitled to the services, this represents 4% of the total18+)) population. Together with the reform’s impressive achievements, this paper also identifies issues related to the target population’s composition and the rehabilitation system’s workforce, budgetary financing, and organizational environment. Toward the end of the second decade, problems between the rehabilitation system, the mental health authorities, and the welfare services became apparent.

**Conclusion and recommendations**: As the Rehabilitation Law enters its the third decade, it is recommended to establish an independent committee of experts to examine needed modifications in light of the conclusions drawn about the first two decades of its implementation.

Keywords: Legislation, community psychiatric rehabilitation, social reforms, Israel

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

Part I – The Rehabilitation Reform: The Law and its Implementation

Foreword

The Community Rehabilitation of Persons with Mental Health Disability Law (hereinafter: The Rehabilitation Law) is one of the most important pieces of social legislation enacted in Israel (Aviram et al., 2012; Community Rehabilitation of Persons with Mental Health Disability Law, 2000[[2]](#footnote-2)) and one of the most advanced examples of mental health legislation of its kind in the world (Drake et al., 2011).

This paper presents a case study of policy change effected by a law guaranteeing people with serious and persistent psychiatric disabilities eligibility for a basket of community rehabilitation services. The reform in rehabilitation that began implementation in Israel in 2001 led to substantial changes in the rehabilitation and the lives of people with such disabilities, and become an important and even essential component of Israel’s ensuing broad reform in mental health (Aviram, 2012; Aviram & Azary-Viesel, 2018a, 2018b; Elitzur et al., 2004; Haver et al., 2005). This important restructuring, implemented in 2015, marked the culmination of the state’s nearly four decades of ongoing efforts to shift the locus of treatment of persons with mental illnesses from a primarily psychiatric hospital-based system to community systems (Aviram, 2010, 2019; Aviram et al., 2006, 2007; Israel’s State Comptroller, 2002, 2007, 2010, 2016).

This effort to effect change within the mental health services has been manifested in, among others, the “structural” reform that led to a reduction in the number of psychiatric beds in hospitals towards the end of the last century and in the “insurance” reform, which, upon becoming effective in 2015 as mandated by the National Health Insurance Law of 1994, transferred insurance responsibility for hospital and ambulatory mental health services from the government to the health funds.[[3]](#footnote-3)

The Rehabilitation Law, enacted in 2000 and budgeted for the first time in 2001, along with the ensuing rehabilitation reform, represents much more than an alternative to long-term psychiatric hospitalization. Drawing on innovative methods for community rehabilitation of persons with serious and persistent psychiatric disabilities[[4]](#footnote-4) and their integration within society, it reflects a conceptual change in public attitudes to people contending with disability due to mental illness, society’s commitment to them, and the methods of helping them recover and integrate into the community (Shershevsky, 2006, 2015, 2022). To put this into practice, the law mandated allocating a dedicated budget for this purpose, and implementing it within a community framework.

The law and subsequent rehabilitation reform created an opportunity to formulate new policies, develop previously unknown knowledge, and implement practices geared to the rehabilitation of persons with psychiatric disabilities, including working in close cooperation with those individuals with mental health problems and their family members. All of this was greatly assisted by the approach of Bill Anthony and his team from Boston University in developing person-centered therapy and recovery-oriented methods.

The rehabilitation system that evolved over the first two decades of the Rehabilitation Law’s implementation can boast extremely impressive achievements. However, towards the end of the second decade, dark clouds began hovering over the rehabilitation system due to difficulties arising from systemic-organizational problems and responses to its functional environment (Emery and Trist, 1965; Thompson, 1967), which became part of the mental health services and had to integrate with the mental health system following reorganization.

This paper’s purpose is to examine the achievements of the rehabilitation system in the two decades of its existence while analyzing the problems impeding its continued proper functioning. We also seek to identify methods for improving the function and role of the rehabilitation system within the framework of the mental health services regarding the rehabilitation, welfare, and quality of life of people with psychiatric disabilities.

Moreover, the discussion of this specific reform in the mental health services will serve as a platform for examining its effects and implications on the other mental health services and social services as well as for discussing the type of issues facing social reforms in general, including the vision and reality needed to effect material policy changes in social services. We argue that reforms do not simply end with the enactment of a law or a decision about policy change: this is simply the beginning. Rather, a true policy change is ongoing and dynamic and achieved by implementing decisions within a specific context. It involves constantly evaluating and measuring its results and contributions to the services provided to the target population and society as a whole.

This paper addresses the target population and the extent of the phenomenon of people with psychiatric disabilities in Israel, describes Israel’s Rehabilitation Law, and analyzes the issues involved arising from its implementation. Following a brief description of the law’s key points, unique nature, and importance, we will briefly discuss the process, circumstances and conditions leading to its enactment. Continuing with a short discussion of the conceptual basis for our assessment, we will then present data demonstrating the achievements of the rehabilitation reform and address the need for strong cooperation and interdependence of the mental health services and the welfare services as a whole. We conclude by looking at the challenges facing the rehabilitation system and its affiliated services, as well as the duty to our target population – people with psychiatric disabilities.

The Study Method

For this paper, we gathered and analyzed statistical data, mainly from the information and assessments of Israel’s Ministry of Health Mental Health Services, the Central Bureau of Statistics (CBS), as well as the National Insurance Institute (NII) Research and Planning Administration. We also conducted a comprehensive review of the literature on the law and its implementation and on Israel’s mental health services since the law’s implementation. We held a series of personal interviews with policymakers, service directors, service providers within the rehabilitation system and the mental health service as a whole, and non-profit organizations (NPOs) supporting people with psychiatric disabilities – the consumers of these services, as well as the NPOs representing relatives of people with psychiatric disabilities.

The Conceptual Framework

The two key guiding concepts for this assessment were the organization’s domain or area of specialization, its activity, and its functional environment. Organizational and inter-organizational theories have addressed these elements, and any evaluation we make must define and confirm the domain or sphere for which the organization is responsible as well as its functioning environment (Aldrich, 2008; Aviram, 1979a, 1979b; Emery and Trist, 1965; Pfeffer and Salancik, 2003; Thompson, 1967).

The organization’s main sphere of activity involves five key components necessary for the organization’s existence and activity: the target population, the funds or budget allocated for its activity, the services provided, the workforce providing the services, and the legal arrangements (law and regulations) regulating its activity.

The organization’s functional environment relates to those institutions and organizations that facilitate or condition the activity of the specific organization according to the above elements, the organization’s inputs and products, and its main activity in the agreed domain (Aldrich, 2008; Aviram, 1979a, 1979b; Emery and Trist, 1965).

The Community Rehabilitation of Persons with Mental Health Disability Law

The purpose of the law is “to act for the rehabilitation of persons with psychiatric disabilities and their integration in the community, in order to enable them to attain the maximal degree of functional independence and quality of life, while maintaining their dignity, in the spirit of the Basic Law of Human Dignity and Liberty” (Community Rehabilitation of Persons with Mental Health Disability Law, 2000). The law is based on two fundamental principles:

a. A person coping with a psychiatric disability has a basic right to rehabilitation.

b. The basket of rehabilitation services allocated to people with psychiatric disabilities should be based on a professional opinion.

The law explicitly provides a detailed account of the rehabilitation basket from which a professional committee can allocate services to a person in need of rehabilitation.[[5]](#footnote-5) This basket included: employment, housing, completing education, social life and leisure, assistance for the relatives of people with mental health concerns, and dental treatment.

Application of the law involves providing from the basket of services based on an individually tailored rehabilitation plan designed to place the person and their desires at the center of the process. Moreover, despite the attempts of the hospitals institutions to obtain a portion of the rehabilitation budget for hospital-based rehabilitation, the law mandates that the rehabilitation budgeting be dedicated entirely to community-based rehabilitation.

The law clearly defines the eligible population: a person above the age of 18 years who has been examined by a psychiatrist or anyone qualified to determine the disability percentage for the payment of NII benefits and for whom a level of at least 40% disability has been determined due to a mental health disorder in accordance with the standards of the NII regulations[[6]](#footnote-6) is eligible to apply for a rehabilitation basket.

The rehabilitation basket is determined by a professional and its receipt does not depend on the budget but is an individual right like any other allowances granted by the NII.

In addition, the law prescribes that the Minister of Health must appoint a national council tasked with: advising the minister on a multi-annual rehabilitation policy; planning community rehabilitation services improving their quality and availability; identifying ways to promote equality among them; setting standards for these service providers; and developing community educational and explanatory programs. The Council is also to report to the minister, provide data on the law’s implementation, and initiate research on rehabilitation-related issues. Council members include representatives from: government ministries responsible for social affairs, including the Ministry of Finance; the professions dealing with the mental health services; local government; the academic world; and organizations devoted to people with psychiatric disabilities and organizations of the families of those coping with mental health conditions. This is the only statutory council in the Ministry of Health directly providing advice to the minister.

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

The process leading to the enactment of the Community Rehabilitation of Persons with Mental Health Disability Law in 2000 can teach us important lessons about what is required for legislation focusing on weaker and sidelined groups within the population.

The initial attempts at community rehabilitation programs for people with psychiatric disabilities began already in the 1960s and 1970s, but these were few and far between and were implemented mainly within hospitals (Aviram, 2007; Aviram et al., 2006; Shershevsky, 2015). Although the National Health Insurance Law (1994) included mental health, it rejected the idea of transferring responsibility for the mental health services from the government to community health organizations, as the law prescribed, nor did it address issues related to community rehabilitation. In view of the failed attempt to implement a mental health reform in 1995 (Aviram, 2007, 2019; Dvir & Shamir, 2017), the authorities understood that psychiatric disabilities, primarily the serious and persistent ones, require special attention, and that adopting appropriate methods of contending with them might facilitate an overall mental health reform (Aviram, 2010). Over the years, a number of measures were implemented, mainly in the form of community sheltered housing programs as an alternative to hospitalization, but these were limited and did not lead to any substantial change (Aviram, 2010; Shershevsky, 2006, 2015, 2022). Concomitantly, but independently from the government efforts to promote rehabilitation, the Knesset undertook an independent effort by to enact legislation arose, which can serve as a genuine lesson in how to promote legislation focused on improving the quality of life of the weaker strata in society. The emergence of the Rehabilitation Law is a prime example of a law evolving from an initiative that began in the legislative rather than the executive branch of government.

Leading this effort was the then Member of Knesset, Tamar Gozansky. While she belonged to a small political party that had never been in government, she had gained considerable respect from her colleagues as a leading social legislator. She skillfully succeeded in establishing a broad coalition of MKs from different parties, professionals, various individuals within the administration and citizens, including relatives of people with psychiatric disabilities, along with public figures who considered the treatment and rehabilitation of people with mental health issues an important issue (Perez-Vaisvidovsky & Aviram, 2019; Shershevsky, 2015). Gozansky insisted that people with a history of hospitalization for mental illness and their families should take part in the discussions to formulate the Rehabilitation Law, which lasted for several years (Shershevsky, 2022). Undoubtedly, her devoted efforts substantially contributed to the continued mobilization and involvement of NPOs representing those with psychiatric disabilities and their families in formulating mental health policy in Israel (Dvir & Shamir, 2017; Lachman et al., 2018; Moran, 2018).[[7]](#footnote-7)

The environmental, legal, political, and administrative conditions also helped Gozansky and the coalition she built to pass the law. The bill she submitted was a private members’ bill, which at that time did not require government authorization and was not subject to any limitations on its cost of its implementation, as was the case with legislation that followed it (Basic Law: The State Economy [Amendment No. 6], 2003).

Originally, the authorities, which included mainly the Ministry of Finance, the Ministry of Health and its Mental Health Division as well as members of the psychiatric profession, had reservations about the law, which was not under their full control. However, once they understood that this separate legislation, while not a government initiative, would promote the broader health reform, and that it had a good chance of getting enacted, despite the objections of the government and the psychiatric establishment, they decided to join Gozansky’s initiative, thereby gaining the opportunity to shape the legislation to reflect their professional and administrative approach (Perez-Vaisvidovsky & Aviram, 2019; Shershevsky, 2006, 2015).

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

We should note that when the Israeli law was first implemented, community rehabilitation was in its infancy in Israel; professionals, whose professional training incorporated mainly treatment-based approaches, had access to scarce resources in this new approach. Fortunately, the encounter with the work of Professor William Anthony and the Center for Psychiatric Rehabilitation at Boston University, along with exposure to other psychiatric rehabilitation approaches (Corrigan et al., 2008), prompted an important learning process aimed at establishing recovery-oriented rehabilitation practices. Professor Marianne Farkas from the Boston Center visited Israel several times to give training sessions and run workshops that contributed immensely to inculcating rehabilitative thinking and integrating new methods of intervention in the mental health field.

Moreover, Israel’s professional community adopted the emerging recovery approach that was becoming accepted globally both by leading professionals (Anthony, 1993) and those with mental health issues (Amering & Schmolke, 2009; Davidson, 2003; Davidson et al., 2010; Roe et al., 2009; Slade, 2009a, 2009b). Essentially, the process was strongly influenced by the fundamentals of the “recovery-oriented” rehabilitation approach emphasizing the following principles: (a) the importance of the assessment and development of “readiness for rehabilitation” of the individual who decides to undergo rehabilitation in order to restore their control over their lives and enable change; (b) the selection of personal goal/s; (c) the formulation of individual rehabilitation programs; and (d) the tracking and development of a method for measuring the process of change and its outcomes.

These principles became the foundations of the practice of rehabilitation in Israel. However, this approach met with considerable opposition from the mental health treatment professions, making it necessary to make changes. At the outset, the recovery-oriented approach differed radically from the then existing knowledge regarding the ability of people with psychiatric disabilities to experience change (Lachman, 2007). Most people would come for psychiatric rehabilitation without actually being ready for such a change, having internalized over the years that there was no point in setting a personal goal and that they lacked the ability to lead a process of change and recovery. An additional challenge involved the attempts of the authorities to exploit the recovery-oriented approach in order to “shift” people from one service to another without properly checking their ability to exercise choice and self-determination, the focal point of the approach (Anthony, 1993; Anthony et al., 1990, 2002; Anthony & Farkas, 2009, 2012; Anthony & Liberman, 1986).

The Target Population

The target population includes persons with serious and persistent psychiatric disorders and with extreme medical and functional disability. We should stress that The World Health Organization ranking of serious and persistent mental health disorders was similar to that of cardiac and cancerous diseases in the Global Burden of Disease (Global Burden of Disease), (Chernichovsky & Bowers, 2014; Murray & Lopez, 1996; Whiteford et al., 2013). This population also suffers from poverty, stigma, and social exclusion.

According to NII data, in 2005, at the time of the law’s initial implementation, there were 52,304 recipients of the general disability allowance who had mental health issues[[8]](#footnote-8) (per the National Insurance Institute definitions) at a level of 40% or higher, as mandated by the Rehabilitation Law. This number grew by 26% by 2010, totaling 65,683 and another 16% by 2015, reaching 76,046. By 2020, a further 26% increase was recorded, with 95,691 recognized eligible individuals (Personal Correspondence, Research and Planning Department, National Insurance, 21.02.2022).[[9]](#footnote-9)

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

Based on the above and drawing on studies conducted on people in Israel with serious and persistent psychiatric disabilities (Aviram & Rosen, 2002; Aviram et al., 1998), the size of the target population at the start of the implementation of the law (2001) can be conservatively estimated at between 85,00–100,000 people. Considering a 46% increase in Israel’s population between 2000−2020, the target population of the Rehabilitation Law can be estimated to number some 150,000 individuals, a ratio of 24 per thousand people in the population within the relevant age bracket (18+)[[10]](#footnote-10) (Central Bureau of Statistics, 2021a).

This number also corresponds with estimates drawn from the literature. If we add to this the relatives of these individuals, who to a large extent bear the onus of care, then we reach a figure of some 350,000−400,000 people (as of 2020) constituting the target population on the primary and secondary levels of the rehabilitation system; a ratio of 57−65 per thousand people at the age of 18 and above within the general population (Central Bureau of Statistics, 2021a).

Clearly, any future planning activity must consider the estimated population growth rate of the age-group eligible population for rehabilitation (about 70% in 2020) in accordance with the Rehabilitation Law[[11]](#footnote-11) (Central Bureau of Statistics, 2021a). In this context, it should be noted that in Israel, the largest group of recipients of a general disability allowance are people whose main reason for receiving it is a psychiatric disorder (National Insurance, 2001; Personal Correspondence, Research and Planning Department, National Insurance, 21.02.2022).

The Economic and Social Cost of Mental Illness

The overall economic cost imposed on society due to mental illnesses and their social ramifications, which has not been measured in Israel to date, is far higher than the government budget set aside for the mental health services (Mechanic et al., 2014). This is the case outside Israel as well. Based on an estimate made in Britain of the economic and social cost of mental illnesses (The Sainsbury Centre for Mental Health, 2003), adjusting for the size of the population and the standard of living in Israel (according to per capita GDP), the annual cost to Israeli society of mental illnesses reached USD 13 billion in the early 2000s (Aviram, 2017). Updating this estimate to 2020, considering only the 47% population growth in Israel since 2000 (Central Bureau of Statistics, 2021a), we can conclude that this cost would have reached about USD 20 billion today. Undoubtedly, the financial and social cost of mental illness and the ensuing disability constitutes a heavy burden that should be researched in depth (Global Mental Health Action Network, 2020; Whiteford et al., 2013).

Furthermore, drawing on the results of the study conducted by Kessler et al. (Kessler et al., 2008) in the United States (adjusting for the per capita GDP and size of the population in Israel), the annual loss in GDP attributable to the non-employment of persons with psychiatric disabilities in Israel was estimated at USD 3 billion (Aviram, 2017). In view of the sizeable increase in the number of residents in Israel and the large growth in GDP in Israel in recent years, this loss is likely to grow.[[12]](#footnote-12) Although these estimates are not precise, they do highlight the inherent financial and social benefits of adopting an appropriate approach to dealing with mental illnesses and the rehabilitation of people with psychiatric disabilities within the community (Zweifel, 2018, 2020).

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

The process of implementing the law was rapid. Already in the first decade of its operation, it enjoyed impressive achievements (Aviram, 2017, 2019; Drake et al., 2011), and these successes continued into the second decade of its application. During these two decades of the rehabilitation reform, the number of rehabilitation patients who received services increased almost fivefold. During 2001, the first year of the law’s implementation, 7,512 patients received services from the rehabilitation basket. The number of rehabilitation recipients rose rapidly, increasing to 14,249 in 2005, 18,758 in 2010, and 30,988 by 2020, reflecting a 150% increase during the first decade of the law’s implementation and 65% during the second[[13]](#footnote-13) (Division of Mental Health, 2008; Personal Correspondence, Ministry of Health, 13.03.2022).

An additional, interesting statistic is indicative of the composition of the population of rehabilitation patients. The introduction of the rehabilitation services in the last twenty years has led to many important results in the effort to enable people with serious and persistent psychiatric disorders to continue their lives in the community and to enable them to belong and play a significant role in running their daily lives. When the law was first implemented, the rehabilitation services allowed thousands of individuals to relocate from hospital beds to locations within the community, which certainly reflected the collective goals of the policy. Already by the end of the first decade of the rehabilitation system’s activity, after the initial generation of those institutionalized in hospitals had already transferred to the rehabilitation system (mainly in community-supported living arrangements), changes occurred in the population in need of rehabilitation. While at the beginning of this period, almost half of those applying to the rehabilitation system were referred from the psychiatric departments in general hospitals and from (government and private) psychiatric hospitals, over the course of time, this number declined sharply, and in 2020 it was only 19%. Concomitantly, the number of those referred from the ambulatory services reached 81% in 2020 (Personal Correspondence, Ministry of Health, 13.03.2022), a number that could also have been affected by the insurance reform that came into effect in 2015 (National Health Insurance Law, 2012).

These changes resulted in a need for the rehabilitation of people with psychiatric disabilities and who were already in the community, (residing primarily in their family homes) at the beginning of the law’s implementation, or those with dual morbidity, as well as young people with psychiatric disabilities but no hospitalization history. Indeed, between 2009−2011, there was a 76% increase in the number of 18−24-year-olds undergoing rehabilitation, while the increase in the general number of rehabilitation patients was only 52% (Division of Mental Health, 2012, 2021). Moreover, the number of rehabilitation patients who were referred to the rehabilitation services without any hospitalization history stood at 27% in 2020 − more than a quarter of the population of rehabilitation patients, compared to 18% in 2001 and 21% in 2010. An additional statistic reflecting the change in the nature of the population of rehabilitation patients refers to the number of people were referred by the ambulatory services without any previous psychiatric hospitalization: at the beginning of the period the number was a low 12.8% of referrals, and by 2020, it had reached 48.7% of this group (Personal Correspondence, Ministry of Health, 13.03.2022).

Examining the nature of the population reaching the rehabilitation system from the hospital system reveals a significant increase in the number of people hospitalized for long periods (one year and more). While in 2001 the number of these individuals accounted for one third of those referred from hospitals (35%), by 2020, most of those referred, 89%, had an ongoing history of hospitalization (one year or more) (Personal Correspondence, Ministry of Health, 13.03.2022).

A change also occurred over the years in the size of the elderly population (65+) among those undergoing rehabilitation, a change which we may assume is connected to the aging of the overall population[[14]](#footnote-14) and possibly also the improved utilization of rights among this age group.[[15]](#footnote-15) We should point out that the number of elderly rehabilitation patients is still lower than the number of elderly persons among the 18+ age group within the overall population (Central Bureau of Statistics, 2002, 2021b), although it is constantly rising.

The rehabilitation system’s expanded activity was reflected in an increase in the budget designated for it. In 2020, the budget amounted to about NIS 1.25 billion[[16]](#footnote-16) (Accountant General’s Division, 2020), and by 2017, the rehabilitation budget had already accounted for 25% of the overall government budget for the mental health services (Accountant General’s Division, 2017). It is important to note that twenty years ago, the government budget for these services was almost non-existent (Accountant General’s Division, 2001).

During the last decade, there has been a noticeable improvement in the scope of activity and the efficiency of the rehabilitation committees, the activity of the monitoring committees, and the level of use of the rehabilitation basket allocations. The number of applications to the first rehabilitation committees increased substantially: between 2010−2020, it rose by almost 50% (2,487 applications were recorded in 2010, and 3,580, in 2020). It is notable that there has been an additional significant increase in the number of applications in the last five years, which stood at 37% (Personal Correspondence, Ministry of Health, 13.03.2022). This could be a result of the insurance reform coming into effect together with numerous applications from the ambulatory services. Furthermore, as noted earlier, many people potentially eligible for the rehabilitation basket do not actually apply and have yet to realize their rights. There was also a concomitant increase in the rate of use of the allocated services risking from 66% during the first six months following an allocation decision at the start of the decade to 80% at the decade’s end.

The changes identified in the two largest areas of services offered by the rehabilitation system, community-supported living and employment, were dramatic during the second decade of the rehabilitation system’s activity. The number of rehabilitation patients in supported accommodation almost doubled, with 8,395 rehabilitation patients using these services in late 2009, and 16,453 by late 2019, a 96% increase. A 69% increase in employment programs occurred during this time, with 8,985 rehabilitation patients using the employment services in 2009, this number rising to 15,179 by late 2019 (Division of Mental Health, 2012, 2021).

A marked increase occurred during the last decade in other services too, such as education, leisure, and community activities (Division of Mental Health, 2008, 2021), all of considerable importance for many rehabilitation patients trying to build a significant life while connecting to the community, as they help reduce social exclusion, and occasionally help prevent superfluous institutionalization. The increase in the number of rehabilitation patients using these services might reflect increased efforts to respond to patients’ personal goals during recovery, a process attributable to the growing professionalization of the rehabilitation system and modern approaches in the field (Anthony & Farkas, 2012; Corrigan et al., 2008). This trend intensified as the external case management service developed, representing a joint effort between those applying for a rehabilitation basket and the professional caregivers to build personally tailored rehabilitation programs as a basis for providing services (Personal Correspondence, Ministry of Health, 13.03.2022).

Our examination of the number of psychiatric beds and inpatient days in Israel during the period of the community rehabilitation reform found a marked decrease in the number of hospital beds during this period. While in 2001 the number of psychiatric hospital beds was 0.85 per thousand population (5,500 beds), this had declined to 0.46 (3,451 beds) in 2010, and by 2019, it had fallen to 0.40 (3,642 beds). Presumably, this reduction can be attributed to the rehabilitation reform, especially community-supported living arrangements (Division of Mental Health, 2008, 2021).

It is reasonable to assume that the decline in the number of psychiatric inpatient days during the period under study provides additional evidence of the rehabilitation reform’s impact on the mental health services. While in 2001, the number of inpatient days stood at 374 per 1000 population (1,722,537 inpatient days), in 2010 this figure was 158.4 (1,207,844 inpatient days), and a decade later, in 2019, it had fallen to 134.7 per 1000 population (1,219,601 inpatient days) (Division of Mental Health, 2008, 2021). Another factor apparently affected by the rehabilitation reform is the number of people hospitalized at the end of the year. At the end of 2001, this figure was 0.8 per 1000 population (5,256 hospitalized), while in 2010, it had declined to 0.5 (3,525 hospitalized), and in 2020 it stood at 0.3 (3,077 hospitalized) (Personal Correspondence, Department of Spokesmanship, Communication and Advocacy, Central Bureau of Statistics, 02.01.2022).

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

* The establishment of the National School for Training in Rehabilitation and Recovery in Mental Health. At the beginning of the first decade of the reform, unique continuous professional training (CPT) sessions for the staff in the rehabilitation systems and preparation of the professionals to work in these frameworks were provided in the context of continuing studies at universities until it became clear that a national rehabilitation school was needed. The school was established in 2009, and in 2011 it moved over to the Ono Academic College, where it continues to operate to this day (Internal Audit Division, 2020).
* Development, inculcation, reinforcement, and integration of knowledge drawn from consumers’ experiences and from service provider consumers. This knowledge was integrated into the field of rehabilitation through consumer movements (persons with mental health concerns and their families) mainly at the advocacy level (Dvir & Shamir, 2017; Grundman et al., 2021; Lachman et al., 2018; Moran, 2018; Naaman, 2018).
* Coordination of community rehabilitation programs – the development of a service for coordinating rehabilitation programs run by private sector entrepreneurs. At the end of the first decade, it was decided to establish a pilot for a model of coordinating external treatment (private) for the services offered by the rehabilitation system:[[17]](#footnote-17) Following the pilot’s result, the Ministry of Health decided to adopt this service model and it is currently operated by an external company (Gelkopf et al., 2016; Pink Hashkes et al., 2013).
* Illness and Recovery Management. Application of the intervention developed in the United States by Professor Kim Mueser (Mueser et al., 2002) and recognized as an evidence-based practice (EBP). Professor David Roe and his colleagues headed the project and it was applied within the system where it continues to operate successfully to this day (Garber-Epstein et al., 2013; Hasson-Ohayon et al., 2007).
* Application of the intervention of readiness for psychiatric rehabilitation (Anthony and Farkas, 2012; Baloush-Kleinman et al., 2018).[[18]](#footnote-18) The intervention is intended to evaluate the rehabilitation patient’s desire for change/rehabilitation and to formulate a plan for increasing motivation as a basis for the rehabilitative treatment. A version of this type of intervention was also developed for ultra-Orthodox rehabilitation patients.
* Social Cognition and Interaction Training (SCIT) – This intervention is designed to improve social skills among people with a psychiatric disability. It emphasizes a series of techniques designed to improve social-cognitive deficits and promote change (Hasson-Ohayon et al., 2014).
* NECT (Narrative Enhancement and Cognitive Therapy) – an intervention for the reduction of self-stigma. Self-stigma is recognized as a key obstacle to a patient’s ability to contend with a mental illness during the recovery process. In light of the importance of this subject and its effects, a recovery-promoting group-based intervention was developed with the aim of reducing the self-stigma of the individual with a mental health issue (Baloush-Kleinman et al., 2018; Roe et al., 2014; Yamin et al., 2012).
* Psychiatric Rehabilitation Routine Outcome Measurement and Quality Surveyors: Establishment of the national project (Roe et al., 2015, 2019; Moran et al., 2017).[[19]](#footnote-19)The objective of the PR-ROM Program is to assess whether and which changes are occurring among the population of rehabilitation basket service consumers in Israel by: defining the eligible population for the services and the actual consumers of these service in practice: evaluating the outcome measures of the rehabilitation basket service consumers over time; and analyzing the decision-making and implementation processes. The program is intended to support the improvement and streamlining of the mental health rehabilitation services in Israel by producing tools to guide the personal rehabilitation processes, processes to enhance the rehabilitation and recovery services in the various rehabilitation frameworks, and national policy.
* The “Quality Surveyors” program[[20]](#footnote-20) develops and conducts satisfaction and quality of life surveys among recipients of mental health services in various community rehabilitation frameworks throughout Israel and among the relatives in the family centers. The surveyors in the community rehabilitation frameworks are themselves people with psychological disabilities, with knowledge drawn from their personal experience (expert colleagues). The surveyors at the family centers are relatives of people with a psychiatric disability. All of them undergo ongoing relevant professional training (Weisberg et al., 2009; Yozma Derech Halev).

(The two above programs were designed to develop tools to monitor the rehabilitation work in order to continue to develop this practice as a routine and to formulate policy based on data.)

* The development of family advice and support centers and the Keshet Program (a Hebrew acronym for Advancement, Participation and Communication). At the beginning of the law’s implementation, Keshet was an intervention intended to provide the families with requisite skills and support for becoming partners in the rehabilitation and recovery processes.[[21]](#footnote-21) The Family Support Centers were created in 2005 and have spread throughout the country in recent years, with 20 active centers today (Shalev, 2017; Weiss, 2013; Weiss et al., 2021).

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

Part II – Towards the Third Decade of Implementation of the Rehabilitation Reform

As the rehabilitation system enters its third decade of action, it faces the need to undergo organizational changes. The first generation of the founders, most of whom have been running the system since its inception, had to rapidly create something out of nothing, draw on deep reserves of creativity, and, often, to improvise. The system grew very quickly and was not always able to adapt itself to the changes and demands of a complex organizational structure, as well as the functional environment which was forced to adapt to the new “neighbor” arriving in the mental health services community.

Issues now facing the system include: a platform based on reliable information; multi-year planning; management transparency; a reinforced staff system; a management and executive layer tailored for the size and complexity of the organization; and an orderly structure for addressing complaints as well as the establishment of a stable relationship with its functional environment, including the Mental Health Division, the entities belonging to the Division, such as hospitals and ambulatory systems, and other community systems, such as the Ministry of Welfare and Social Affairs, local authorities, private sector service providers, and, of course, the individuals with mental health issues together with their families (Israel’s State Comptroller, 2007, 2010, 2016).

In addition, the supervisory and control system was not well adapted to the type of rehabilitation tasks in question and the new professional values. Generally, the workforce is insufficient, an appropriate examination of the suitability of the implementation of programs to their goals is lacking (Israel’s State Comptroller, 2007, 2010, 2016), and to date, no research establishment has been set up to evaluate and promote the rehabilitation programs.

As noted, the rehabilitation reform led to structural changes in the mental health services immediately from its first decade, and, as we have seen, both the number of the psychiatric beds and the full number of inpatient days have decreased considerably during the period of the law’s implementation.

Although the significance of these changes (some of which are referred to as “the structural reform”) should not be underestimated, analysis of the data reveals some disturbing results. In contrast to other countries that have implemented mental health reforms, and whose subsequent reduction in the number of psychiatric beds led to the closure of government hospitals for the mentally ill (see for example Goodwin, 1997; Mechanic & Rochefort, 1990), in Israel, not even one government hospital for the mentally ill was closed. Furthermore, the main decrease in the number of psychiatric beds in Israel was due to the reduction in the number of private hospital beds, and even from the closure of some of these hospitals or a redefinition (and consequently the cost) of some of these beds (Aviram, 2012). Moreover, we should mention the criticism leveled by the State Comptroller (Israel’s State Comptroller, 2007) that the hospitals’ inpatient budget had not been reduced despite the reduction in the number of psychiatric beds, and his recommendation that funds from the hospitalization budget should be redirected for investment in community-based programs. It is possible that the inpatient budget remained unchanged despite the reduction in the number of beds because of a budgetary deficit of the hospital system, or possibly due to “political” considerations involved in gaining the support of the hospital system for the Rehabilitation Law.

Moreover, in its 2010 report, the State Comptroller (Israel’s State Comptroller, 2010) criticized the Ministry of Health, stating that the inpatient budgets were high in comparison to the budgets for ambulatory and rehabilitative treatment in the community. Of course, an effort should be made to reassess this issue in light of the results of the insurance reform that shifted responsibility for the mental health clinic services from the government to the health funds in 2015. The Supreme Court (Supreme Court of Israel, 2022) has recently heard the lawsuit of the Israel Psychiatric Association against the Ministry of Health, challenging the alleged overcrowding in hospitals and essentially demanding additional hospital beds. *Bizchut* (The Israel Human Rights Center for People with Disabilities)[[22]](#footnote-22) which joined as an *amicus curiae*, claimed that it would be better to develop community-based responses (Reznik, 2022). This organization has recently been trying to delay the plans of the Mental Health Division and the Ministry of Health to establish institutions in both urban and rural locations for long-term patients released from psychiatric hospitals; instead, it is trying to find rehabilitation solutions for this population within the various communities. Indeed, it is important to relieve psychiatric hospitals of the responsibility of providing ongoing treatment for people who do not require acute treatment or continued hospital care. At the same time, an effort should be made to avoid transferring these people to closed institutions without trying community-based rehabilitation for them (Bizchut, 2022).

We now turn to further discussion of future programs and the allocation of funds and budgets to the mental health services.

One of the popular claims at the time, mainly among Ministry of Finance officials, was that the budgetary allocation for the rehabilitation reform was “new money,” or a supplement to the budget, above and beyond what had been previously allocated for the mental health services. However, in-depth analysis of budgetary trends shows that this claim is baseless. The budget item designated for funding the rehabilitation services and the funds directed to these services were indeed new. However, as a rule, not only did the state not add funds to the mental health budget, but it actually saved considerable amounts already during the first decade of the law due to the marked decrease in the number of inpatients. It can be assumed that during the first two decades of the Rehabilitation Law’s implementation, the saving was at least NIS two billion, and this without considering the saving of additional costs associated with adding infrastructure to accommodate increases in the number of inpatients (Aviram, 2017; Aviram et al., 2012). Therefore, it is arguable that not only did the state not add any supplementary funds to the mental health budget, but it actually did not fully use all the money it had saved from reducing hospitalization to reinforce rehabilitation services and clinic-based services in the community.

Of course, we should examine whether these trends discussed in the first decade of the rehabilitation reform continued into the second decade of the rehabilitation reform’s activity as well as which rehabilitation services were either adversely affected or not provided at all due to this “savings” for the State of Israel.

As of 2019, some 50% of the overall budget allocated for the mental health services in Israel was earmarked for psychiatric hospitals, more than the amount invested in the rehabilitation system and the ambulatory services together, 31% and 12%, respectively (Shlafman, 2021). This despite the criticism leveled by the State Comptroller (Israel’s State Comptroller, 2007, 2010) on this matter and the marked decline in the number of inpatients.

Also worrisome is that in the recently approved government budget (January 2022), in which a special budgetary supplement for mental health approved, in addition to the regular budget for this field, most of the budget was allocated to the government hospitals for the mentally ill (The Health Committee, 2021).

Another failure in our opinion, which has already been referred to in the evaluation of the first decade of the rehabilitation reform and touched on regarding the transfer of the mental health services to the health funds as part of the insurance reform implemented in 2015, involves the efforts to avoid “earmarking” the budget transferred to the health funds for the mental health services (Aviram & Azary-Viesel,2018a, 2018b; Aviram, 2017). The mental health budget designated for the health funds (which accounts for about one half of the total state mental health budget) is swallowed up in the general budget of the health funds and there is no way to determine how much has actually been spent on the mental health services or whether the health fund has properly directed all the funds transferred to its budget for those services. Unfortunately, these concerns have been found to be justified. A article recently published in the daily newspaper *Ha'aretz* reported that the health funds use some of the money allocated for mental health for other purposes (Efrati, 2022).

It is curious what the interest of the health funds and the Ministry of Finance was in this policy; it is also interesting to identify the resulting consequences or damages. As the mental health system, including all its three key components – hospitalization, clinics and rehabilitation – operates in unison, in our opinion, this policy harms the rehabilitation services too.

Moreover, the approved NIS 50 million (approximately USD 15 million per annum for rehabilitation activity in the community, such as opening frameworks for community rehabilitation and releasing chronic inpatients from hospitals while providing support for balancing homes in the community were not transferred to the rehabilitation system budget, but will be used in other frameworks. Are these data indicative of an end to the rehabilitation reform and its declining impact on the mental health system in Israel?

The Target Population

As we have mentioned, according to conservative estimates, the population eligible for the psychiatric rehabilitation services (in 2020) amounts to 150,000 people.[[23]](#footnote-23) Even assuming that only half this population would need or be interested in receiving rehabilitation services, this would still involve a total of 75,000 people. Therefore, according to the 2020 statistics, only 40% of the target population actually receives rehabilitation services.

Any planning for the rehabilitation system must address specific population sectors and distinct age groups, while drawing on knowledge on topics such as morbidity rates and their presentation within these population groups, as well as the traits of these groups as a whole. For example, the data indicate that the number of mental health service recipients among the Arab population in Israel, 20% of the population in Israel, is lower than their proportion of the population (Kaplan et al., 2019; Lurie & Fleischman, 2019; Roe et al., 2019). The State Comptroller (Israel’s State Comptroller, 2010) also raised the issue that the response of the rehabilitation services to the Arab population is insufficient. In addition, the system will have to pay special attention to the elderly population, in which the number of people with psychiatric disabilities is higher in comparison to younger age groups. There was a marked increase in the number of rehabilitation patients of age 65 and above throughout the years of the law’s implementation, amounting to 2,360 people in late 2020; and the proportion of this population among the total number of rehabilitation patients rose by 160% between 2001 and 2020 (Kaplan et al., 2019; Lurie & Fleischman, 2019; Roe et al., 2019).

We believe that the rehabilitative services in the community are neither able to nor should be expected to provide an adequate response to the needs of people with psychiatric disabilities combined with other medical and complex disabilities. Therefore, such people need support from the health funds’ ambulatory clinics and from other social welfare organizations. In view of the long wait for service from the ambulatory clinics in the community (Israel’s State Comptroller, 2010, 2020), steps should be taken to improve the service for this complex population.

While the drafters of the Rehabilitation Law assumed that the existing community welfare services would continue to provide assistance to people with psychiatric disabilities due to their eligibility for welfare services, and thereby enhance their rehabilitation within the community, in reality, the opposite happened. Many local authority welfare services, viewing the Rehabilitation Law as a good opportunity to make budgetary savings, referred people with psychiatric disabilities, who were otherwise eligible for local welfare services, to the rehabilitation system. For example, during the COVID-19 pandemic, many local authority welfare services that distributed food baskets to the needy did not include rehabilitation patients among the eligible recipients (Mazlawi, 2020; The Special Committee for Welfare and Labor Matters, 2020). The State Comptroller (Israel’s State Comptroller, 2016) commented on the importance of the cooperation between the Ministry of Health and the Ministry of Welfare and Social Affairs for the treatment of complex populations, and mentioned the deficiencies in their joint work.

An additional issue that arose during the study of the law’s implementation related to the interpretation given to the theoretical basis of the recovery theory and the identification of appropriate rehabilitation patients for rehabilitation. For example, questions arose about the suitability of certain people for rehabilitation and the extent to which this can be predicted especially after an extended period of hospitalization. Additionally, we questioned whether it is both desirable and possible to provide community-based treatment for people with disabilities who require a certain level of supervision while avoiding creating “mini” community hospitals[[24]](#footnote-24) and while also overcoming the rehabilitation system’s interest (similarly to that of large organizational systems generally) to sometimes prefer providing services to people with a high likelihood of achieving success. These are issues that require consideration of empirical findings on this matter and to theoretical and social factors. In this regard, we did try to look at the number of applications for community-based rehabilitation that are rejected and the reasons for that rejection. This issue is not published in the statistic reports, and data about it should collected, reported, and exposed to criticism.

We must add to the target population for the rehabilitation services 200,000–250,000[[25]](#footnote-25) relatives caring for those with psychiatric disabilities and who also need support services that are essential for the rehabilitation process. It is notable that in the data published by the Ministry of Health regarding the rehabilitation system, there is no reference to the support provided to the families, although this topic is discussed and presented as a key change within the system. It is not clear why this activity is not reported despite having been operating comprehensively since 2006, and the data on it, like other services in the system, should be published.

Although we do not have access to full data on the number of relatives receiving support, guidance, and other rehabilitation services as required under the Rehabilitation Law, it is doubtful whether the number of service recipients among them reaches even the number of people with psychiatric mental themselves. To date, no research has been conducted regarding the cost to the family, although it is clearly significant both economically and mentally, certainly when the rehabilitation patient lives in the family home (Dvir & Shamir, 2017). In some welfare states, the family’s role has actually been defined as that of a caregiver and there is orderly legislation to provide support for these families (see the Care Act, 2014, in Britain). Unfortunately, this issue has not received sufficient attention, not to mention appropriate legislation in Israel. We believe that support should be given to those families caring for a family member with serious psychiatric disabilities, as is the norm in other countries, and that there is a need to promote legislation on this issue. Appropriate aid for these families might also actually save the state money by preventing further cases of hospitalization and other interventions resulting from lack of support from the family to the individual with a psychiatric disability.

**Budgets**

As already discussed, during the first decade of the law’s implementation, there was an impressive increase in the rehabilitation budgets, and their portion of the overall mental health services budget grew. These changes might be somewhat misleading for two reasons. First, at the beginning of the period, the allocation earmarked for rehabilitation was negligible. Second, this increase does not necessarily mean that the funds allocated for the establishment and development of the rehabilitation system correspond in practice with the requirements of the law and the system’s needs. Moreover, while in its original planning, the legislature believed that budgets for rehabilitation would also increase by pooling budgets from other authorities, in practice, today, in many cases, the authorities actually refer those in need of services that were previously funded from their budgets to the rehabilitation system (see for example: Mazlawi, 2020; The Special Committee for Welfare and Labor Matters, 2020).

In the initial years of the law’s implementation, the budget for the rehabilitation patient (regulated according to the median wage of salaried employees in 2020, see table) increased substantially, by a rate of 61% – from NIS 19,619 per capita in 2001 to NIS 31,600 per capita in 2005. However, in the subsequent years, no noticeable change occurred in the budget, so that in 2010, it was NIS 31,819 per capita – an increase of only one percent. During the last decade, the budget for the rehabilitation patient continued to increase, and in 2015, it amounted to NIS 34,829 per capita (an increase of 9%), and in 2020, it reached NIS 39,668 per capita. In total, the budget for the rehabilitation patient has doubled over the course of the last twenty years (see Table 1).

We should point out that this calculation relates to the actual budget in practice, and thus does not take into account the budgetary steps taken by the system to deal with the potential growth in the target population and the number of rehabilitation patients. In fact, the State Comptroller (Israel’s State Comptroller, 2007, 2016) commented on a number of occasions about the possible reduced number and even non-existence of rehabilitation committees due to the lack of resources. Moreover, it is noteworthy that the overall budget for the mental health services in Israel is rather low in comparison to other developed countries. Similarly, the proportion of private expenditure on mental health services in Israel appears to be relatively high in comparison with most OECD states, and it is considerably higher than the proportion of private expenditure on all health services in Israel, which obviously contributes to unequal access to private sector mental health services (Mental Health Organizations Forum, 2021).

(Table 1 here)

\*The data are from the Accountant General’s Division publications (2001, 2005, 2010, 2015, 2020) and personal correspondence (Accounting, Ministry of Health, 22.03.2022).

\*\* The extent of the expenditure each year was adjusted to the 2020 price level based on the median wage of salaried employees for a working month (National Insurance, 2003, 2007, 2012, 2017). As the wage data were published only in 2018, an estimate was made of the median wage in 2020. The calculation was made by adding the rate of change occurring in the average wage from the end of 2018 to the end of 2020. The median wage of salaried employees in the relevant years (the rates of increase appear in parentheses): 2001 – 4,685 (-); 2005 – 4,626 (1.3%-); 2010 – 5,518 (19.3%); 2015 – 6,716 (21.7%); 2020 – 7,481 (11.4%).

\*\*\* The number of rehabilitation patients during the year. The number of rehabilitation patients during the year is 18% larger on average than the number of rehabilitation patients at the end of year.

(Table here)

As may be recalled, most of the rehabilitation services are operated by private parties, with the state providing the budget and supervising them. One common claim is that one of the reasons for the decline in the quality of the rehabilitation is the non-realistic pricing in the tenders for the rehabilitation services (David, 2020; District Court of Haifa, 2022). As we have already pointed out, regarding housing, for example, the pricing was even lower than the norm for parallel state-run programs. For example, the support for sheltered accommodation for people in need of welfare services in accordance with the guidelines of the Ministry of Welfare and Social Affairs is considerably greater than the amount of support for accommodation services for people receiving them under the Rehabilitation Law operated by the Ministry of Health. We have also uncovered that the usual payments for the staff in the welfare services are greater than those allocated under the tenders to the staff in the rehabilitation services provided by the Ministry of Health (District Court of Jerusalem, 2017).

Consequently, many potential private service providers avoid bidding for tenders, leading to a reduction in or absence of competition and resulting government dependence on the few private parties operating the services, as the government must implement the law’s requirements and ensure the provision of rehabilitation services. Moreover, the unrealistic pricing of the tenders can lead to a deterioration in the quality of the services, as the private providers strive to avoid financial losses. We have noticed a phenomenon whereby entrepreneurs enter tenders and make a low bid that might actually prevent them from making a profit, or even incur losses, so that they can win larger tenders in the future and revise their earlier terms at a later date. The State Comptroller (Israel’s State Comptroller, 2007, 2016) has reported on the selection of service providers even without tenders being submitted. In light of all this, it is important to examine this issue and to budget the tenders in a manner that is conducive to genuine competition and at the same time will guarantee appropriate supervision and oversight, thereby preventing a market failure leading to inferior quality in the rehabilitation services and the rehabilitation patients’ rights.

Workforce

The workforce operating the services is a vital element in determining service quality and even the extent of the law’s implementation. When addressing the issue of the requisite workforce during the first decade of implementation of the Rehabilitation Law, the State Comptroller (Israel’s State Comptroller, 2007, 2010, 2016) declared that the workforce running the service, operating the rehabilitation committees, dealing with supervision and oversight, and coordinating treatment was far from adequate for proper operation of the rehabilitation system. Clearly, it is imperative to develop and guarantee appropriate parameters for the size of the workforce needed to perform the requisite tasks of the rehabilitation services. We should point out that despite the central role played by the workforce in the rehabilitation system, there is no published data on the quantity or quality of its workforce. In view of the importance of this issue and related issues that have arisen during the course of the law’s implementation, such data should be monitored and included in the Mental Health Division’s publications.

In our opinion, no suitable promotion track for community psychiatric rehabilitation has yet been devised. As the professional workforce comes from various professional disciplines (mainly occupational therapy and social work) the promotion tracks in these professions do not properly reflect the field of rehabilitation in the community. Furthermore, according to estimates we have received, 70% of the workforce working in the rehabilitation services (operated by the private sector, as stated above) is not professional, involving positions such as counselors and mentors accompanying the patients who require no more than a *bagrut* or matriculation (12-year study) certificate. Under their work agreements, this workforce receives the minimum wage and frequently has no promotion track available. Therefore, there is a very high volume of staff turnover and great difficulty in recruiting workers, leading to the conclusion that the level of service needs to be improved.

It is also recommended to examine to what extent today, more than twenty years after the law’s implementation, a specific background in psychiatric rehabilitation training is a required precondition for employment in community psychiatric rehabilitation. Alternatively, perhaps continuous professional training (CPT) is also required while working in the field of rehabilitation. At the time, a discussion was held on the issue of creating a specific profession of rehabilitation for persons with psychiatric disabilities (Roe et al., 2011), but regardless of whether a specific profession of psychiatric rehabilitation develops or a specialization in the rehabilitation of persons with psychiatric disabilities will occur within various different professional disciplines, it is still important to maintain and promote a skilled team within the system. The development of a promotion track is crucial for this purpose.

In this context, it is important to note the activity of the National School for Training in Rehabilitation over the course of the last decade. In recent years, an audit report was issued regarding the National School for Training in Rehabilitation (Internal Audit Division, 2020). The report examined how the school functioned in terms of both administration and content and suggested reexamining basic issues in its operation in the event it continued operating in the same format. Additional issues that should be addressed include: whether training at the school should be a precondition for employment; whether the study track should require subsequent work in the field of rehabilitation; whether the remuneration reflects the level of training; and whether there is an appropriate promotion track for the rehabilitation workers. We are certain that the National School for Training in Rehabilitation plays a critical role in promoting the workforce and advancing the field of rehabilitation; nevertheless, it must address the issues raised in the audit and make any necessary corrections.

Services

Since the Community Rehabilitation of Persons with Mental Health Disability Law was drafted in the Knesset in the 1990s, the rehabilitation basket has not been evaluated and no changes have been made in it. The State Comptroller (Israel’s State Comptroller, 2010) has commented on this and proposed examining the basket. Decisions on this matter should be made based on: empirical evaluations of the existing basket; accumulated knowledge on this issue from Israel and around the world; reference to changes in the composition of the population applying for rehabilitation, such as the increase in the number and rate of both the young and the elderly; applications of people with complex needs, such as people with multiple disabilities, comorbidities and/or personal disorders; and changes in the background and culture of some of the people applying for rehabilitation services. The State Comptroller (Israel’s State Comptroller, 2016) claims that even when initiatives and new services are added, clear standards are often not set for their operation. Moreover, budgetary considerations and defined priorities must be addressed. It is important to indicate that although priorities should be determined on the basis of knowledge, social aspects must also be considered. This requires a public debate attended by experts, professionals, legislators, and, of course, the relatives and individuals with mental health issues themselves.

Another issue requiring attention is the rate of utilization of the rehabilitation basket given to people applying to the rehabilitation committees (Personal Correspondence, Ministry of Health, 13.03.2022). While the majority of people applying to the rehabilitation committees do have the rehabilitation basket approved (the rate of approval stands at 90%–92% in the period of 2010–2020), a high proportion of the approved services are not utilized. The average rate of utilization of the overall services in 2010, 2015, and 2020 was only 40%. We might have imagined that a higher rate of utilization would have been reported for the housing and employment services, but many people also did not exercise their eligibility for these services.[[26]](#footnote-26) The State Comptroller (Israel’s State Comptroller, 2007, 2010, 2016) has also addressed this problem, and although it has been ongoing for many years, it is not clear if it is due to bureaucratic difficulties, inappropriate allocation, or other reasons (Moran et al., 2015). Certainly, this issue should be examined in depth.

There is one area of the rehabilitation basket where the rate of utilization is relatively high. As far as “case management” is concerned, the rate of utilization rose from 44% to 83% in 2015, although dropping to 60% in 2020. The question of whether these data are indicative of a more professional approach of the rehabilitation system together with an effort to build rehabilitation programs that are sensitive to the rehabilitation patients’ personal goals is of both theoretical and practical importance and should be studied.

We have mentioned the issue of selecting the appropriate population for rehabilitation, which raises the question of whether it is possible to provide treatment in the community for people who need a certain level of supervision without creating “mini” community hospitals. This issue, recently raised by Bizchut (2022) in relation to a tender due to be issued by the Ministry of Health, also involves the interest of the rehabilitation system, like other organizational systems, in preferring to provide services to people with a high likelihood of achieving success in their rehabilitation process. As previously noted, despite the importance of gathering data on the number of applications for rehabilitation that are rejected, along with the reasons for their rejection, this information is not included in the statistical reports that have been published.

Another issue requiring attention is that of the employment of rehabilitation patients in a reduced minimum wage arrangement. The National Labor Court (2021) recently ruled that it is prohibited to deny rights under the labor laws to individuals employed within the rehabilitative employment systems. This is a pivotal and fundamental ruling, explicitly stipulating that employee-employer relations apply in protected workplaces, whose workers are entitled to full rights under the law. However, the court did not rule on the question of reduced minimum wage, which is customary in rehabilitative employment frameworks. This issue must be addressed due to the negative ramifications for the rehabilitation process of granting a reduced minimum wage, and in light of other considerations relating to the concept of justice and the rights of an individual employed by a rehabilitation framework (Israel’s State Comptroller, 2016).

In this context, an additional issue requiring attention involves rehabilitation services run by government-approved NPOs that receive conditions that make it easier for them to raise funds from the public. This has ramifications far beyond the rehabilitation of persons with psychiatric disabilities. A recently published article claimed that the CEO of an NPO running a protected facility for individuals with psychiatric disabilities and paying the rehabilitation patients a reduced minimum wage was paid an extremely high wage (Heruti-Sover, 2021). Such situations should be addressed by the government (the regulator) to determine whether there should be legal limits on the wages and administrative expenses of NPOs benefiting from preferential conditions that help them raise funds from donors.

An additional matter for attention involves emergency treatment in mental health emergencies experienced by rehabilitation patients, whether they are in sheltered housing other rehabilitation facilities in the community, such as hostels or supported communities, or even in their family residences. Remarking on this issue, the State Comptroller (Israel’s State Comptroller, 2007) noted delays in the establishment of psychiatric emergency centers as well as staff shortages. The lack of skilled emergency teams for intervention during a crisis in the community could lead to unnecessary hospitalization, police intervention, and sometimes even transfer of the rehabilitation patient during the crisis to the prison system. Moreover, a lack of appropriate and immediate treatment by the emergency teams might lead to community opposition to the rehabilitation of individuals with psychiatric disabilities in the community, increased stigma, and reluctance of family members to provide care at home for their relative with psychiatric disabilities.

Another important issue is that of support for the families of rehabilitation patients. Despite the importance of this issue, it has not received adequate attention during the first two decades of the law’s implementation and no statistics about it have been published. We believe that assistance should be provided to those families caring for a relative with a psychiatric disability; relevant legislation similar to that as in other countries should be initiated (Care Act, 2014). Providing adequate assistance to families of rehabilitation patients might also prevent cases of additional hospitalization and interventions, thereby saving money.

There are additional issues, some raised in this paper, which already could be seen as requiring attention and a response during the first decade of the legislation. Among these are: the phenomenon of “hostelization” – the difficulties encountered by persons with psychiatric disabilities in moving to less restrictive housing in the community; problems with exercising their rights and the choice of services; the low rate of rehabilitation in the Arab Israeli sector (Israel’s State Comptroller, 2016); the long waiting period for housing solutions; a low rent subsidy rate coupled with the lack of choice in certain areas (District Court of Jerusalem, 2017); differential support for rent according to the area of residence in which the rehabilitation patients prefer to live or should live due to their family’s location; a lack of suitable regard for and sufficient cultural sensitivity toward special populations; inadequacies in the continuing follow-up treatment after hospitalization, including coordination between clinical and rehabilitative systems; partial and insufficient coverage of case management services (Israel’s State Comptroller, 2007, 2010, 2016); and challenges faced by occupational rehabilitation solutions within the free market (Aviram, 2012; Israel’s State Comptroller, 2016). Moreover, there is a need to expand the options for those under the age of 18 to complete their high school education and of other to complete studies for a bachelor’s degree.

As the various elements of the mental health services system operate as an interconnected system, the rehabilitation network depends on the functioning of the inpatient and ambulatory systems as well as on the general health system and the social services. We believe that the clinic services should expand the focus of their activity far beyond psychotherapy services to address the vital needs of people with serious and persistent psychiatric disabilities. Moreover, the ongoing erosion of the community-based mental health clinics (Aviram, 2010), the reports of the rehabilitation patients on extremely long waiting times to receive ambulatory treatment from the health funds (Efrati, 2022; Israel’s State Comptroller, 2010, 2020), and the lack of efficient cooperation with physical healthcare, the clinical mental health network, and local welfare services (Israel’s State Comptroller, 2016) – as is the case today – will clearly have a negative impact on the functioning of the community-based rehabilitation system and adversely affect its ability to fulfill its intended purpose. These issues, too, need addressing.

Evaluation and Research

Evaluation studies on rehabilitation processes and their outcomes are of course vital both professionally and for budgetary purposes, but these are still scant. Although a number of evaluation studies have been conducted over the years both by researchers from the academic establishment[[27]](#footnote-27) (Gelkopf et al., 2016; National Outcome Psychiatric Rehabilitation Monitoring Implementation and Research Program, 2018) and by individuals with mental health issues (Quality Reviewers Program, 2019; Weisberg et al., 2009; Weisberg & Westman, 2014), the number and scope of these studies cannot begin to cover all the programs in the rehabilitation system. The State Comptroller (Israel’s State Comptroller, 2007, 2010) also addressed this matter, commenting on the extremely limited number of studies in this field and recommending allocating additional resources for such research. In the last report on this matter, he stressed that most of the outcome measures developed were not actually in use and had yet to produce results within the rehabilitation system (Israel’s State Comptroller, 2016).

Furthermore, evaluation studies are of vital importance for bolstering this field’s public legitimacy, especially in light of the public weakness and social exclusion of the population for whom the Rehabilitation Law was enacted. It would have been appropriate to adapt the National Health Insurance Law arrangement, whereby a certain percentage of the budget is allocated for research and evaluation. While this approach was not mandated in the legislation – although perhaps it should have been – it should be possible to move ahead and further this issue via administrative means, even before revision of the law. It is imperative to decide on priorities for research and evaluation periodically and to ensure that the allocation of funds for the researchers is made independently of the operational system and based on independent, scientific evaluation alone. Undoubtedly, such an arrangement would support and expand the scientific community dealing with the study of the community-based rehabilitation of people with psychiatric disabilities, as well enhance the study of mental health policy and services in general.

Community Rehabilitation for Persons with Psychiatric Disabilities and the Mental Health Insurance Reform

One of the key problems that the rehabilitation reform will need to address during the third decade of its application relates to the results of the implementation of the insurance reform that has been in place since 2015 (National Health Insurance Law, 2012). This problem stems from, among other factors, the fact that while the responsibility for the mental health inpatient services and clinic services were transferred to the health funds, the rehabilitation services have remained under government responsibility. The health funds will have both a therapy-related and financial incentive to transfer anyone suitable for community-based rehabilitation to the government rehabilitation system; however, that system will be dependent on the state budget and on other authorities in terms of its ability to provide the requisite services. On the other hand, the efficient functioning of the ambulatory and inpatient services, and, above, all the requisite coordination between the clinical services and the rehabilitation services to ensure continuity and quality in treatment will not be under full government control. All these are discrete systems with differing interests that might lead to disputes (Linder-Ganz, 2016; Supreme Court of Israel, 2016).

Furthermore, the budgetary supplement given to the health funds for assuming responsibility for the mental health services was not “earmarked” and there is no way of knowing whether the full budget set aside for the mental health services via the health funds is indeed used for this purpose or is transferred to other areas of medicine, as was recently published in a newspaper article (Efrati, 2022). It is not surprising that the health funds were not eager to reveal the actual use of their budget, but it emerges that the Ministry of Finance officials who conducted the negotiations on the insurance reform shared this reluctance, as they did not want the state to be exposed to additional demands to provide budgetary support to the mental health services (Aviram & Azary-Viesel, 2018a, 2018b). Consequently, the rehabilitation system will thus be subject to two-pronged (organizational and budgetary) pressure, and its functional environment (namely the organizations and networks engaged in fixed, reciprocal relations with it, and which influence its functioning) will have interests that do not necessarily dovetail with its own or contribute to its proper functioning.

Organizational Problems and the Status of the Rehabilitation System in the Mental Health Services

The rehabilitation system operates within the organizational structure of the Ministry of Health and is subordinate to the Mental Health Division. Towards the end of the second decade of the rehabilitation reform, organizational difficulties arose between the rehabilitation system and the Ministry of Health’s Mental Health Division. Among the disagreements that arose were questions about the relationships, management and control, and even the organizational position of the rehabilitation system. Unquestionably, the mental health services must operate as a synchronized and interconnected ecosystem, but on occasions, there will be some friction among the organizational systems comprising these services.

Moreover, presumably, there is some degree of incongruity between the organizational culture of the Ministry of Health, which in addition to fulfilling the role of government regulator, was (and still is) a clinical, medical services provider, and the community rehabilitation system, which, in its essence, is an organization with a strong social orientation.

As is the case with many disputes of substance, personal differences were likely a factor here too. In early 2021, these led to the resignation of the person who headed the rehabilitation system during its second decade, as well as disruptions in the relationship between the Mental Health Division’s management and the National Council for Community Rehabilitation of Persons with Mental Health Disability, an advisory body under the law to the Minister of Health on the issue of the Rehabilitation Law and its practical implementation. Recently, a psychiatrist with a relatively limited background in rehabilitation was appointed as head of the rehabilitation system as part of a broader framework of her position as the Division Deputy Head in the Mental Health Division,[[28]](#footnote-28) but no specific manager or head was appointed for the rehabilitation system itself. Furthermore, the administrative and professional responsibility for a number of new issues relating to the community rehabilitation services that were included in the new 2021/2022 state budget for mental health were not transferred to the auspices of the rehabilitation system. Moreover, a number of issues have arisen relating to the ability of workers to sustain long-term employment in the rehabilitation system and to the recruiting of appropriate professionals for this field. Are these events and issues symptomatic of a structural problem in the mental health services or an organizational attempt by the Division to improve the mental health services? Or perhaps they represent an effort by the psychiatric system to regain full control over mental health, which has been adversely affected following the establishment of the rehabilitation system, and possibly also as a result of the trends of maintaining separation between the rehabilitation system and the Mental Health Division? Have these all been misinterpreted, or are they possibly simply the result of organizational and personal misunderstandings between those heading the organization and those on the frontline of community-based rehabilitation for persons with psychiatric disabilities? Time will tell.

Concluding Observations

Although this review has provided a brief bird’s-eye view of this topic, it does teach us about the ability of the legislators, professionals, elements within the public sector and civilian organizations to unite and work for a common vision to generate change via a resolute and well-planned and cleverly executed campaign. Following enactment of the Community Rehabilitation of Persons with Mental Health Disability Law (2000), psychiatric rehabilitation in Israel shifted from theory to reality. The law enabled the fostering of the values and adoption of the operational methods proposed by professionals in the field, such as William Anthony and his colleagues, and many others. Now, two decades later, the rehabilitation system in Israel is a genuine enterprise, which has had a significant impact on the lives of tens if not hundreds of thousands of people with psychiatric disabilities and their families.

Certainly, the rehabilitation reform can boast of impressive achievements over the course of the two decades of its implementation; nonetheless, its continued success should not be taken for granted. While it is possible to correct some of the problems identified here with the help of the body responsible for carrying out the rehabilitation itself, a considerable number of them depend on other systems and factors over which the rehabilitation system has no control. Following the changes that have occurred since the Rehabilitation Law was enacted, the coalition that supported the law might begin to dissolve. Both administrative and professional attention is being devoted to the situation arising from the implementation of the insurance reform in mental health (National Health Insurance Law, 2012; Wikipedia). There is no way to know how this might affect the rehabilitation reform remains the government’s responsibility, while inpatient and ambulatory services have been transferred to the health funds. Furthermore, we are concerned that the lingering effect of the COVID-19 pandemic on the economy as a whole, including the health and social welfare services, will take its toll on the rehabilitation services too.

After all, policy change is an ongoing event that does not end following enactment of the law. The state of affairs emerging from this study distinctly underscores the need to monitor the practical implementation of this policy. It also highlights the need for commitment to the change, even after enactment of the law and its successful implementation. Unfortunately, mental health, including rehabilitation within the community of persons with psychiatric disabilities, is an issue relegated to the sidelines of public interest. In addition, the fact that this involves a weak population, suffering from stigma and social exclusion, impinges on its ability to have an impact on the policy change regarding it.

Therefore, the professionals who provide care and treatment for this population, together with those in society, however few and far between they may be, who care deeply about people with psychiatric disabilities and their quality of life bear a heavy moral and professional responsibility. An effort should be made to organize a political and public lobby. With the help of the population with psychiatric disabilities and their families and relatives, this lobby must place the topic on the public agenda and take action to preserve, develop, and advance the rehabilitation reform. It may even be appropriate to appoint an independent, external committee of experts to examine this issue and propose a rehabilitation plan for the coming decades. The establishment of such a professional committee and a public lobby would certainly have ramifications on future implementation of the insurance reform, as well as on the quality and effectiveness of all the mental health and welfare services in Israel. Ultimately, these efforts will be reflected in the quality of life of those with psychiatric disabilities along with their families and the community as a whole.

1. . [↑](#footnote-ref-1)
2. Link to the English translation of the law (The Mental Health Division):

Community Rehabilitation of Persons with Mental Health Disability Law, 2000.

<https://www.health.gov.il/English/Topics/Mental_Health/rehabilitation/Pages/default.aspx> [↑](#footnote-ref-2)
3. Organizations with a similar function to the HMOs in the United States. [↑](#footnote-ref-3)
4. The law uses the term “mentally disabled” as this preceded the terminology change inspired by the International Convention on the Rights of Persons with Disabilities (United Nations, 2006), as well as by work on the link between language and stigma (Granello & Gorby, 2021). [↑](#footnote-ref-4)
5. According (former) MK Tamar Gozansky, who initiated the law, inclusion of the rehabilitation basket as an integral part of the law was intended to clearly define the services and prevent efforts to delay implementation of the law or its dependence on regulations or the budget, and thus to enable its immediate implementation following its enactment (Private interview, October 16, 2021). [↑](#footnote-ref-5)
6. According to Sections 33 (organic mental health disorders, schizophrenia and delusional disorders) and Section 34 (mood disorders [affective disorders]) of the NII. While the receipt of a disability allowance from the NII depends on the loss of earning capacity, the right to apply to the rehabilitation committee depends purely on a medical diagnosis of disability due to mental illness with a rate of at least 40%. [↑](#footnote-ref-6)
7. An NPO representing persons with psychiatric disabilities – Lishma (the organization’s name is a Hebrew acronym for the integration of those persons coping with mental health issues and their empowerment) along with NPOs of families of those with psychiatric disabilities such as Hitmodadut (Coping), Ozma (Strength), and Mishpachot Briyut Hanefesh (Mental Health Families). [↑](#footnote-ref-7)
8. Items 33 and 34 alone, as these are the deficiencies listed in the Rehabilitation in the Community of Persons with Mental Health Disability Law (2000). [↑](#footnote-ref-8)
9. It should be pointed out that eligibility to apply to the rehabilitation services derives from disability due to medical reasons of at least 40%, while the general disability allowance is granted to a person due to the loss of earning capacity, so that a 40% disability may not necessarily mean automatic eligibility for a general disability allowance. [↑](#footnote-ref-9)
10. The calculation was made in relation to the general population in the 18+ age bracket, as this is the relevant age group for eligibility for the Rehabilitation Law. [↑](#footnote-ref-10)
11. The number of persons aged 18 and over in Israel’s population in 2020 stood at an average of 6,185,500, comprising 67% of the overall population (Central Bureau of Statistics, 2021b). It is also noteworthy that the rate of population growth in Israel is relatively large in relation to the other OECD states. In the twenty years since 2000, the population in Israel has grown by 47% (Central Bureau of Statistics, 2021a). [↑](#footnote-ref-11)
12. For the study year in the United States [Translator comment: Not clear to what this refers].

 Between 2000–2020, the GDP in Israel rose by 200% from USD 133 billion in 2000 to USD 409 billion in 2020. As this is a limited population, we may assume that their contribution to this increase would have been much more moderate, if any. We may thus have to add to the estimate of USD 3 billion only the component of inflation for 15 years at a rate of 15%, to reach a figure of USD 3.5 billion. [↑](#footnote-ref-12)
13. It is noteworthy that the 65% increase in the number of rehabilitation patients was considerably greater than the 21% growth in the general population during that period (Central Bureau of Statistics, 2021a). [↑](#footnote-ref-13)
14. Life expectancy in Israel has been on the increase in recent decades (Central Bureau of Statistics, 2021c). [↑](#footnote-ref-14)
15. Over the years, there has been a marked increase in the number of rehabilitation patients aged 65 and above. In late 2001, this number accounted for only 3.23% of those undergoing rehabilitation (187 people), and by late 2020, had reached 8.40% (2,360 people) (Personal Correspondence, Ministry of Health, 13.03.2022). [↑](#footnote-ref-15)
16. According to Bank of Israel data (2021), the average exchange rate in 2020 was NIS 3.44 to USD 1. According to this calculation, the actual expenditure budget of community rehabilitation for persons with psychiatric disabilities amounted to USD 357,336,046. The cost per rehabilitation patient amounted to USD 11,531. The cost per thousand people in the relevant age group (18+) was USD 57,769 [Translator comment: This figure does not seem to logically correlate with the previous figure marked in yellow]. [↑](#footnote-ref-16)
17. The pilot was operated in conjunction with the Ministry of Health and the L.N. Tauber Foundation and accompanying research was conducted by Haifa University to assess the model’s influence on the results of the rehabilitation activity. Thirty “rehabilitation program managers” treated 900–1200 rehabilitation patients during a 5-day period. This team was trained by Professor Marianne Farkas from Boston University in accordance with the rehabilitation approach to mental health developed there by the team led by Professor Bill Anthony. [↑](#footnote-ref-17)
18. In a joint venture (headed by Professor Galia Moran from Ben-Gurion University) between the Ministry of Health, the Israel Psychiatric Rehabilitation Association, and Boston University, seven senior professionals were trained to apply the intervention in the field of rehabilitation. [↑](#footnote-ref-18)
19. The “Psychiatric Rehabilitation Routine Outcome Measurement (PR-ROM) Program is a national program involving the Rehabilitation Unit in the Ministry of Health Mental Health Services Division, the Laszlo N. Tauber Foundation, and the Haifa University Center for Mental Health Research, Practice and Policy. [↑](#footnote-ref-19)
20. From “Yozma Derech Halev” (Initiative from the Heart). [↑](#footnote-ref-20)
21. Keshet was set up by Professor Naomi Hadas-Lidor based on the theoretical model of Professor Reuven Feuerstein. [↑](#footnote-ref-21)
22. A Non-Profit Organization devoted to promoting the rights of people with disabilities in Israel. [↑](#footnote-ref-22)
23. As of 2020, the relevant population of 18+ was 24,000 people (Central Bureau of Statistics, 2021b). [↑](#footnote-ref-23)
24. [↑](#footnote-ref-24)
25. This was the case at the outset of the deinstitutionalization period in the United States (Segal and Aviram, 1978). As of 2020, the relevant population of 18+ was 32,000–40,000 people (Central Bureau of Statistics, 2021b). [↑](#footnote-ref-25)
26. The rate of utilization for housing services ranges between 54% and 57%, while for employment services it was lower and has even declined over the years – from 41% in 2010, it reached only 37% in 2020. [↑](#footnote-ref-26)
27. A specific project in this field developed at Haifa University and a number of PhD dissertations have been prepared on this topic. [↑](#footnote-ref-27)
28. She resigned from her position after only seven months of work. [↑](#footnote-ref-28)