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**Mental Health Policy in Israel**

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**Israel’s Community-Based Mental Health Services**

**Abstract**:

In this chapter we will review Israel’s mental health system policy development and highlight its unique community-based mental health services. Many of the policies implemented in Israel are based to a large extent on the Western model of psychiatry, with certain modifications for the unique needs of Israel’s diverse society and developments regarding the human rights of persons with disabilities. The overview will also discuss the future of community-based mental health services and the need to promote a community reform in order to implement the mental health recovery concepts.

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**Israel – Mental Health System Development in the Israeli Context**

Israel is a relatively young, multicultural state, with considerable national, religious and ethnic diversity. Since its establishment in 1948, Israel has been in a constant state of emergency, including a long-standing conflict with the Palestinian population. It has also had to contend with the complex issue of nationality among its Palestinian Arab citizens. The state, established in the wake of the immensely collective trauma of the Holocaust, immediately faced the challenge of taking in millions of Jewish refugees from all over the world, mainly from Europe and the neighboring Arab States, in a very short period of time.

The current population of Israel amounts to some 9,291,000, of which 6.870 million are Jews (73.9% of the overall population), 1.956 million Arabs (21.1%), and 465,000 other ethnicities (5.0%) (The Central Bureau of Statistics, 2020). This cultural diversity is attributable, among other things, to waves of immigration over the years; some 25% of today’s population was not born in Israel. The last waves of immigration arrived in the 1990s with a mass influx from Russia and Ethiopia. Added to this complexity is, of course, Israel’s precarious security situation, both external and internal, as mentioned above.

It is in this complex and challenging environment that Israel’s mental health system, reflecting both Western psychiatry and more traditional systems (Levav & Grinshpoon, 2004), must operate. The health system is based on the National Health Insurance Law, 5754-1994, according to which all residents are entitled to medical insurance coverage via the Health Tax according to their level of income. Most of the population receives treatment via one of the four Health Maintenance Organizations (HMOs) that were established by trade unions even prior to the state itself (Aviram, 2019; Levav & Grinshpoon, 2004).

There is a lack of precise data in Israel as to the number of people diagnosed with Serious Mental Illness (), or people contending with psychosocial disability, an issue common to many other countries. The health system estimates that about 130,000–150,000 people in Israel are estimated to be living with SMI. If we add to this the family members taking care of them, we then arrive at a number closer to 400,000 people who are affected by mental health problems, out of a total population of 9 million people. In fact, the population of people with psychosocial disabilities in Israel represents the large proportion of people with disabilities, amounting to 41% of those receiving disability pensions (about 115,000 men and women) (Aviram, 2019; David, 2020; Aviram & Azary-Viesel, 2015; The National Insurance Institute 2014, the National Council on Rehabilitation, 2021). While the issue of mental health problem clearly affects a large portion of the population, the accepted view of people with psychosocial disabilities is rife with structural, public, and personal stigma toward those affected.

In terms of data on psychiatric hospitalization, in 2019 there were 58,641 visits to the psychiatric emergency rooms (ER) at both the general and psychiatric hospitals, 63% of which were at government hospitals. Forty percent of those visits ended in hospital admissions, one third of those under the age of 25 were hospitalized compared with 44% of those 25 years or above. A total of 3,475 of the 3,642 beds in Israel’s psychiatric hospitals are located in public hospitals (Ministry of Health, 2020).

As is the case with other countries too, mental health is a sphere that has long been sorely neglected in Israel, both in terms of the response and services provided for the unique needs of those with psychosocial disabilities and mental illness, and also in terms of the professional aspect of developing innovative professional practices (Aviram, 2019; David, 2020; WHO, 2021).

As noted in the opening of this chapter, the State of Israel evolved as a multiethnic immigrant state. In its early days, government authorities had to focus their efforts on developing and establishing the very institutions of the state, including systems to help accommodate millions of immigrants arriving in the aftermath of the Holocaust. Even in the early days of the state, a mental health system had to be developed to provide a relevant response to those affected by the traumatic events of that period, including the numerous cases of Holocaust survivors, immigrants and even the state’s founders, who required psychiatric treatment (Aviram, 2019; Aviram & Shnit, 1981). At that time, there was an urgent need to provide a psychiatric response for many suffering from mental illness, and emphasis was placed on separating them from the general population and placing them in psychiatric institutions. This usually involved involuntary commitment, and the quality of treatment was vastly inferior to the treatment of physical illnesses (Mark & Siegal, 2009).

While mental health policy in the early days of the state may be considered somewhat minimal, or even primitive, social welfare legislation in Israel was much more significant. Even from its inception, the State of Israel enacted broad social legislation (Gal & Benish, 2018; Hovav, Lawental and Katan, 2012). Thus, the health and mental health systems developed as discrete organizational and professional systems, separate from the social welfare and education structures. To this day, the health and mental health services are operated via the central government and the HMOs, rather than via local government, as is the case with other welfare systems.

The mental health system in the early days of the state was based mainly on the mental health services that developed during the British Mandate that ruled in the country between 1917–1948. As such, it existed in hospitals, non-profit organizations, and private profit organizations, alongside institutions of the pre-state HMOs that provided medical treatment within the community. At the time, belonging to one of these HMOs was based on affiliation to one of the trade unions, and these HMOs gave marginal attention to mental health at best. The national, and later, state mental health system provided a response to those who did not belong to the HMOs, and consequently it began to allocate budgets for the various psychiatric institutions (both the public and private ones) which were already operating at the time (Aviram, 2019). The health system was based on the independence and power of its physicians, the Government Hospital Directors’ Forum, who had a monopoly in the field of mental health. Their power and bias in favor of hospitalization often delayed and even prevented the implementation of changes towards more community-based solutions (Aviram, 1991, 2019; Ginath, 1992).

Mental health legislation, especially the enactment of the Treatment of the Mentally Ill Law, 5715-1955 (which has since been amended on several occasions) in the early years of the state, reflected the hospitalization approach. Consequently, the budgetary sources originating from contributions of philanthropists and various funds were mainly used in support of hospital beds and inpatient days (Aviram, 2019). Until the mid-1960s, emphasis was placed on increasing the number of hospital beds and providing a response to those in need of hospitalization. During the 1960s, attention began to be paid to the serious problems of mental health hospitalization. Already at that early stage, calls were heard for a change in the existing arrangements and for reorganization of the mental health services to reduce long-term hospitalization, along with initial discussions on prevention and rehabilitation instead of hospitalization (Aviram, 1991). In the early 1970s, there were more than 8,000 hospital beds for psychiatric patients in all the hospitalization institutions in Israel. This represents 2.7 beds for every 1,000 residents (compared with 1.3 in 1948 and 0.4 in 2016) (Aviram, 2019, 1991).

The lack of hospital beds, together with social and professional developments, led to a change in the early 1970s, at first mainly in terms of the dialogue on the required changes. This appeal emanated both from a bottom-up approach by social organizations calling for changes in the field, along with expansion of the social approach advocating integration within the community, together with forces from within the government. One example is that of the State Comptroller’s Office, which in the early 1970s examined the psychiatric and mental health system and commented on the lack of community-based solutions to provide support (State Comptroller, 1970). The first attempt to effect a change in mental health policy and reform arrived in the form of the Ministry of Health’s 1972 reorganization program. The program was based on understanding the new trends, mainly in the United States, which advocated transferring the focal point of the mental health system from the psychiatric hospitals to community mental health services, mainly by downsizing the number of hospital beds, reducing the number of inpatients and the length of hospital stays, along with developing and making available community mental health services to the population (Aviram, 2019; Ministry of Health, 1972). The program proposed enhancing community mental health service centers (based on the model of the Kennedy administration in the United States), whose objectives were providing therapeutic services in the vicinity of the patient’s home and providing preventive services to counter the development of individual, family, and social pathology (Aviram, 2019; Tramer, 1975, 1981). The program emphasized the fundamental concepts of the community approach to mental health: regionality (accessibility), comprehensiveness, and continuity of care (the constancy and variety of the services). The original program proposed establishing a district community center in each geographical area in Israel to serve the community and provide hospitalization and emergency services, out-patient clinics, partial hospitalization, along with counseling, and education services. This was based on the understanding that coordinated work with the various health and welfare agencies would be a prerequisite for implementation of such a program, along with adapting them to the health and mental health services framework. The main argument in favor of the deinstitutionalization program was a resulting significant decline in the number of inpatients that would reduce hospitalization costs and enable the closure of lesser quality private hospitals. (Aviram, 2019).

This program was neither budgeted nor implemented and the funding for the psychiatric hospitalization system remained unchanged. Despite the calls to reduce the number of hospital beds during the 1970s, their number actually increased. Aviram (2019), who studied and analyzed this policy failure, discovered that despite the inherent promise in this program of reducing hospitalizations, it was not implemented, due both to the positions of various pressure groups, and to the budgetary method that tended to prefer hospitalization. Added to these impediments was the fact that community mental health was still at an embryonic stage. Hospitals are allocated budgets directly as independent units based on the number of beds and their occupancy (Aviram, 2019; Aviram & Levav, 1981). The initial community centers established were located around the psychiatric hospitals, which reinforced the medical hospitalization establishment, thereby influencing the social perception of mental illnesses and the mental health services (Aviram, 2019). An additional attempt to change the funding of the mental health services and the division of responsibility between the state and the HMOs in 1977 following the political power shift in Israel from a left-wing social democratic government to a right-wing administration also met with failure. The actual state of mental health service funding was something of an anomaly – people who came to hospitals, the mental health centers and the government sponsored community services, received free service, while those patients referred to a general hospital by the HMOs for psychiatric treatment were charged. This state of inequality had an adverse effect on those in need of treatment and led to problems in the development of the psychiatric services that continued to be dependent on the state budget (Aviram, 2019; Elizur, 1998).

In the 1990s, changes in this field were planned as part of the work on the enactment of the National Health Insurance Law, 5754-1994, which established universal health insurance in Israel. The planned changes for the mental health system were intended to improve the availability and accessibility of the services, streamline them economically, tailor the services for the needs of the consumers, and release individuals from institutionalization and integrate them into the community. This reform included a number of components, among them: the inclusion of mental health services in the basic health services basket provided by the HMOs, thereby essentially transforming the government apparatus into one that relied more on market forces; organization of the mental health services into district administrations; establishment of a fund for the treatment of the chronically ill; and reorganization of the Department of Mental Health Services, thereby effectively releasing it from any direct responsibility for the provision of services (Aviram, 1997, 2019; Aviram & Rosen, 1998; Mark & Shani, 1995).

The planned move reflected a shift to a multi-dimensional integrative perception of individuals removing the artificial separation between the physical and the mental; promoting equal rights for people with mental health conditions, reducing stigma and bolstering normative attitudes towards mental health conditions. It also constituted an incentive for streamlining and developing the system, building community services, and better deploying services. This move dovetailed economically with the processes of privatization and outsourcing of the health and welfare systems, which began to gain momentum during the 1980s, driven by the perception that the alternative of community treatment would reduce hospitalization costs (Aviram, 2019; Benish, 2012; Report of the State Commission of Inquiry into the Functioning and Effectiveness of the Israeli Health Care System, 1990).

The proposed National Health Insurance Law stipulated that within three years of the law taking force, the responsibility for mental health would pass over to the HMOs, as these services were to be included in the state health services basket (Aviram, 2019). This was supposed to help promote mental treatment, as, according to the principles of the law, the health services should be available, equal, and accessible to residents close to their homes (Feldman & Rabinowitz, 1996; Shemer & Venonen, 1995). The proposed reform was based on the principles of mainstreaming and integration, representing the approach that there should be no separation between physical and mental problems. (Aviram, 2018, 2019; Mechanic, 1993).

Despite the substantial work to include mental health within the law, this move was delayed for several years and was not implemented. The delay in introduction of the insurance reform in this area was the result of a number of factors, above all, economic and conceptual aspects of the mental health sector. It is important to understand that there are multiple players in the mental health sector in Israel: the HMOs, the state psychiatric hospital directors, the trade unions, and especially the unions representing the psychiatric hospitals, the representatives of the various professional disciplines within the field of mental health and within civil society, including the members of the family organizations, non-profit organizations and legal defense organizations, as well as the contractors providing mental health services in the community. The delay in the reform resulted from the reluctance of the policy makers and the HMOs to move ahead with this initiative. Moreover, the delay was also affected by the slow growth of the consumer organizations in Israel, along with the limited influence of the civil society organizations at that time on the policy makers, and their limited ability to promote the reform against the power of the Ministry of Finance, the hospital, and HMO directors, along with the systemic and public perceptions of mental health, which were heavily infused with stigma toward the issue (Aviram, 2019; Aviram, Guy & Sykes, 2006; Mark 2011). This trend is also reflected in the budget that was largely granted to the psychiatric hospitals over the years (Aviram, 2007, 2019; Ministry of Health, 2000, 2004).

In the decades that have elapsed since enactment of the Public Health Insurance Law in 1994, pressure has been brought to bear about mental health issues from several directions. From the grassroots level, civil society organizations began a more serious effort to push for change and transferring the insurance responsibility for mental health to the HMOs. Within the civil society organizations themselves, there were those who favored delaying the reform, mainly the public psychology organizations who were afraid of the reform’s implications on the state of public mental health and treatment availability. Nevertheless, a coalition was formed of relevant mental health organizations, including the organizations of the families and those people themselves coping with mental health conditions, organizations representing the rights of people with disabilities, and service organizations that espoused promoting the reform and who regarded it as the key to a conceptual change in relation to mental health.

The State Comptroller also pointed to the country’s growing mental health needs, and thus the resulting need to move ahead with the reform, and transfer responsibility to the HMOs, while dealing with those factors preventing such progress (State Comptroller, 2010, 2016).

An additional factor involved in formulating and promoting mental health policy is the courts. The courts in Israel play a significant role, both in the development of legal rulings and the defense of the rights of patients in psychiatric hospitals under the Treatment of the Mentally Ill Law, as well as in the defense of their constitutional rights as part of hearings in the High Court of Justice (Mark, 2011). The Supreme Court of Israel also accompanied this process over the years, hearing petitions filed by the civil society organizations, the coalition of organizations and the family organizations that called for the implementation of the government decision from 2003 to transfer responsibility for the mental health services to the HMOs (HCJ 5777/05 **Bizchut – The Israel Human Rights Center for People with Disabilities et al. v. Minister of Health**). To a certain extent, this case served as a catalyst for state decision-making between 2005–2012. In 2012, the government decided to implement the reform, setting aside a period of three years for prepare for this change, and this was stipulated in a government order (National Health Insurance Order, 2012).

After numerous postponements, in 2015 the insurance reform in Israel was launched, according to which outpatient treatment, which until then had been administered by the mental health clinics, was transferred to the HMOs in Israel that provide medical services within the community. The insurance reform supplemented the hospitalization reform (downsizing the number of hospital beds) and the rehabilitation reform that included enactment of the Rehabilitation in the Community of Persons with Mental Health Disability Law, and the establishment of the rehabilitation setup in Israel, and thus represented a substantial step in reducing stigma and promoting the approach of linking physical and mental needs (Government decision 4611, dated May 10, 2012). During the waiting period following enactment of the National Health Insurance Law in 1994 and the passing of the reform, the Rehabilitation in the Community of Persons with Mental Health Disability Law was enacted, which deals separately with the rehabilitation reform undergone by the mental health system in Israel in 2000.

**Rehabilitation in the Community of Persons with Mental Health Disability Law – Mental Health in the Community is Laid Down in Law for the First Time**

This section presents the material change that came in the form of the Rehabilitation in the Community of Persons with Mental Health Disability Law in 2000, which prescribes an innovative national level model of psychiatric rehabilitation in the community, regulated by the central government and administered on a national basis.

Psychiatric rehabilitation took time to develop in the world. The theories of Bill Anthony and others helped to formulate a different practice based on a number of principles (Anthony & Furlong-Norman, 2011; Corrigan, Mueser, Bond, Drake & Solomon, 2008):

1. The belief in people’s ability to recover and integrate within the community. Every person coping with psychiatric disabilities has the “strengths” alongside the “disabilities” that should enable that person to gain independence and control of the course of their life.
2. Recognition of the importance of the ability of a person to choose for themselves what is important to promote in their life to create a meaningful life for themselves.
3. The importance of equipping a person with new skills to facilitate better self-management.
4. A person’s readiness for change and ability to generate motivation are related to setting personal goals, which that person chooses independently.
5. Everybody lives within and belongs to their surroundings and community; the community’s involvement and the use of natural community resources will improve a person’s ties with the community.
6. Experience-based knowledge and people with experience-based knowledge are important to create a rehabilitation treatment setup based on co-production.
7. Social, self and professional stigmas constitute a significant barrier to promoting these objectives and the efforts of any person on the way to recovery. Therefore, intervention is necessary to reduce stigma.

Psychiatric rehabilitation in the community helps in the effort to adopt strategies for coping better with the disorder and placing integration in the community as a key to independent life. Rehabilitation, which evolves from a social, community approach, seeks to change the focus from symptoms and diagnoses to the strengths and goals of the individual as part of the recovery movement. (Lachman, 1998; Lachman & Hadas-Lidor, 2008; Roe, Lachman & Mueser, 2009; Roe, Garber-Epstein & Khatib, 2019). The recovery movement stressed the ability to help people with SMI to live a meaningful life in the community, based on personal choice, despite the disability with which they must cope, using practices proven to be effective (Davidson, L. et al, 2010; Deegan, 1993; Drake at al., 2001).

The models of psychiatric rehabilitation and the importance of the community services began to develop in Israel back in the 1960s, and the psychiatric institutions also developed rehabilitation services in the community, mainly for patients who tended to be hospitalized for drawn-out periods or who were subject to repeat hospital stays (Mark & Siegal, 2009). Some of the growth in the development of rehabilitation was based on family community initiatives along with the activity of non-profit organizations (NPOs) such as Enosh, the Israeli Mental Health Association, one of the more long-established organizations founded in 1978. Enosh began as an organization of family members seeking to advance mental health policy and to develop services in the community for people with SMI, dealing with living accommodations, employment, social life, and leisure (Enosh website; Sykes, 2003; WHO, 2003; WHO, 2021). The development of the variety of community responses and their professional establishment enabled the creation of a substantial basis to include the field of rehabilitation in both legislation and policy in Israel, such as in the early stages of the supplement to the National Health Insurance Law, and later on as part of the enactment of the Rehabilitation in the Community of Persons with Mental Health Disability Law (Mark & Siegal, 2009).

The changes in attitude to people with disabilities took placed against the backdrop of additional trends of change, mainly the efforts to promote legislation of the Equal Rights for Persons with Disabilities Law, 5758-1998, and the ensuing regulations (Feldman, 2008).[[1]](#footnote-1) The Equal Rights Law, which was advanced by the civil society organizations, and above all by *Bizchut* – The Israel Human Rights Center for People with Disabilities, formulated a new language in relation to people with disabilities and marked the beginning of the public discourse on the subject of disability. The official representatives of the State of Israel were even among those who later drafted the Convention on the Rights of Persons with Disabilities (CRPD) and introduced insights into it garnered from the process of enacting the Equal Rights Law.

Moreover, a professional organizational framework began to be established in the Ministry of Health, which started to develop a nationwide network for rehabilitation in the community, stressing the need for the individual’s maximum ties to and integration within the community in all walks of life (Shershevsky, 2021). Initially, the responses focused chiefly on housing and employment services, alongside processes for the deinstitutionalization of chronic patients in both state and private hospitals, with the aim of reducing the number of hospital beds, and these also focused on the community centers located alongside the hospitals.

נוכח העובדה ששירותי השיקום לא קיבלו תקציבים ולא הוגדרו מנגנונים פורמליים למתן שירותי השיקום

The need for rehabilitation services led to the introduction of new practices and new psychiatric developments in accordance with the Treatment of the Mentally Ill Law, which enabled the duration of hospital stay to be reduced. However, due to the delay in introducing the insurance reform and the transfer of responsibility for the provision of the mental health services to the HMOs, the rate of development of these new services slowed down and budgetary allocations to the rehabilitation system were held back, based on the argument that it was necessary to wait for clarification regarding the demarcation of responsibilities between the government and the HMOs (Mark & Siegal, 2009).

It is for this reason that in the late 1990s, MK Tamar Gozansky initiated the Rehabilitation in the Community of Persons with Mental Health Disability Law. The law defined a new sphere of community rehabilitation services for people with psychosocial disabilities. The objective of the law is “to enable **rehabilitation and integration in the community** of persons with a mental health issue so as to enable them to attain a maximum possible level of functional independence and quality of life, while maintaining their respect in the spirit of the Basic Law: Human Dignity and Liberty.” The rehabilitation basket or the services to which an individual is entitled are defined in the first supplement to the law, which specifies “help with referral and funding” of the following services: employment, housing, completing education, social life and leisure, dental treatment, short vacations and consultation, training, and guidance for the family members of people with psychosocial disabilities. It also prescribed the appointment of a treatment coordinator to be responsible for implementation and coordination of all the services provided to an individual with mental disabilities. The law also stipulates the establishment of a national council for rehabilitation in the community of persons with psychosocial disabilities, and many of the law’s various clauses touch upon this. The council has considerable importance in terms of advising the minister and the ministry in relation to multiannual national rehabilitation policy decisions, planning the rehabilitation services and improving them, development of broad programs of public diplomacy in education, changes in the rehabilitation services basket, and setting standards for the rehabilitation service providers. The council is supposed to receive reports and data on the implementation of the law and to initiate studies on rehabilitation. This council has been given precedence in discussions on changes to the law and how they are to be implemented. It also has an important role to play in relation to the potential issues of involvement and visibility of people with mental health concerns and their families in their interaction with the government ministry (Aviram, 2019; David, 2020; Rehabilitation in the Community of Persons with Mental Disabilities Law).

The service-organizational responsibility, the budgetary and funding element, as well as the supervision and oversight, remained under state control, while the service itself was provided by the service providers, some of them NPOs and some commercial corporations (Aviram and Azary-Viesel, 2015; David, 2020).

The legislative model was based on determining the individual’s eligibility and receiving approval from a district, professional rehabilitation committee. The function of the rehabilitation committees is to determine the eligibility of an individual applying for rehabilitation services, to ensure that the services are tailored for the individual’s needs, and to examine the specific rehabilitation programs along with the auxiliary services from a service basket defined in the law. The law also defines monitoring committees as a supervisory mechanism to monitor implementation of the rehabilitation program that is built together with the individual, and to examine the changing needs and apply relevant changes to the program accordingly. The individual appears before the committee to present his or her program, and generally should be accompanied by his or her family and main treating practitioner. Once an individual is found to be eligible for the rehabilitation basket, and their application is approved, that individual should then conduct a “market survey” together with the referring authority, and select the appropriate framework or service, often more than one, designed to meet the needs of the rehabilitation program. Examination of the manner in which these services are supplied has shown there to be numerous barriers to the actual implementation of the rights and failure to exercise these rehabilitation rights is extremely prevalent (Baruch et al., 2015; Benish & David, 2018; David, 2020; Khatib, 2015; State Comptroller, 2016).

**The Development of Legislation for the Rights of People with Psychosocial Disabilities**

In order to understand the overall development of legislation, we present here a number of items of legislation laid down over the years that have affected the protection afforded to the rights of people with psychosocial disabilities in Israel.

**The Treatment of the Mentally Ill Law**, 5715-1955, reflected the classic psychiatric medicine model, helping to bolster the trend of institutionalization (Aviram & Shnit, 1981). Between 1970–1980, draft amendments were proposed on five occasions, but none of them included any reference to the community mental health services policy. Amendment No. 4 to the law from 1977 actually reinforced the status of the district psychiatrist, once again bolstering the trend of institutionalization. (Aviram, 2019).

Mental health has always been perceived by politicians as a marginal social issue, as it has traditionally been associated with an excluded and essentially invisible population. Consequently, any effort to address the area was deemed to lack any political gain, and there was therefore no real incentive to focus attention on it. To this, we might add the lack of public, civil forces supporting the efforts to advance these topics as well as the lack of media attention to them (Aviram, 2019).

The Treatment of the Mentally Ill Law was amended in 1991 and it stipulates the requisite conditions for hospitalization, evaluation, and involuntary psychiatric treatment. There are two tracks for application of the law – a civil track regarding an order for psychiatric evaluation by the district psychiatrist, and a criminal track via court order. The law enables an individual to receive legal representation at the psychiatric committees both by the Ministry of Justice’s Legal Aid Department and the Public Defense in cases of criminal proceedings (Feldman, 2008).

As observed above, the investment of resources and the focus of Israeli legislation over the years, mainly in the field of institutionalization, combined with the inequality in the division of resources between the hospitalization institutions and the community mental health services, has created a social climate that encouraged involuntary commitment and a resulting breach of human rights (Feldman, 2008). In 1992, the following Basic Laws were enacted in Israel: Human Dignity and Liberty and Freedom of Occupation, which led to a more in-depth discourse on the topic of rights, and in 1996, the Patient’s Rights Law was enacted, which defines the rights of an individual who seeks medical treatment, including the right to available, proper medical care, without discrimination, and to be treated with respect and consideration along with the right to privacy, and also regulates the issue of informed consent (Feldman, 2008; Melamed, Shnit, Kimchi, Elizur, 1999). There has been a significant discourse on the reciprocal relations and tension between the Patient’s Rights Law and the Treatment of the Mentally Ill Law, 5751-1991, which imposes treatment due to mental disability (Mark, 2011).

The Equal Rights for Persons with Disabilities Law, enacted in 1998, provided an additional safeguard to guarantee the rights of people with psychosocial disabilities. The law aims to defend the dignity and freedom of a person with disabilities, to prescribe such a person’s right to equal and active participation in society in all walks of life, and to provide an appropriate response to that person’s special needs, in order to enable them to live an independent life, as far as possible, in privacy and dignity, while making the most of that person’s inherent capability. The law stipulates the establishment of a Commission for Equal Rights of Persons with Disabilities, stating that its functions shall include advancing the fundamental principles of the law; promoting equality and preventing discrimination of people with disabilities; and fostering the integration and active participation of people with disabilities within society. The law prescribes that the rights of people with disabilities and the commitment of Israeli society to those rights are based on acknowledgement of the principle of equality, recognition of the value of all humans who are created in the image of God and the principle of human dignity. In addition, the law defines the right of persons with disability to make decisions regarding their own life and encourages affirmative action for them. In terms of employment, the law determined that it is prohibited to discriminate against an individual due to his or her disability in relation to being accepted for work, and the terms of work and promotion, provided that the individual is fit to function. In order to facilitate the principle of equality, the place of work must make relevant modifications for the worker (for example, equipment, training, and working hours) as long as such an effort does not impose an unreasonable burden on the employer.

In 2006, Israel signed the International Convention on the Rights of Persons with Mental Disabilities, ratified in 2012. Since then, the State of Israel has been involved in implementing the principles of the convention, both via internal legislation and by promoting an inclusive climate for people with psychosocial disabilities to express their views in various forums and to formulate policy. In Israel there are still many barriers limiting the access of people with psychosocial disabilities and there is an animated discourse on implementation of the convention and how to assimilate it within the civil society organizations (Shadow Reporting to the UN Committee on the Rights of Persons with Disabilities, 2020).

**The Positive Effect of the Rehabilitation Law along with the Difficulties in its Implementation**

Rehabilitation is a field based on principles focused on the individual and the personal process created between that person and the surroundings in order to further his rehabilitation in the community. The Rehabilitation Law in general regards rehabilitation as “a process within the community designed to develop the capabilities and skills of people with psychosocial disabilities, in order to guarantee the achievement of the greatest possible level of functional independence and quality of life accompanied by medical oversight, including each of the following: realization of the rights of people with psychosocial disabilities to housing, employment, education and professional training; as well as training in the development of social skills and use of leisure time” (Section 2 of the Rehabilitation Law). The underlying professional approach to the field of psychiatric rehabilitation is one of recovery. The professional practices and the services that developed, referred to as “rehabilitation services,” include recovery-oriented interventions, focusing on the individual process, processing the mental crisis, coming to terms with the illness and managing it, early identification of para-psychotic symptoms, enhancing social skills, self-identity and esteem, and coping with social stigma and empowerment of strengths, skills, and hopes, in a different manner to the clinical definitions. (Fawcett, 2012; Kleinman-Balush et al., 2018; Knaifel & Mirsky, 2015).

Psychiatric rehabilitation includes a variety of basic principles, some detailed here. Above all, working together with the recipient of the service, including joint decision-making between the professional staff and that individual; supporting the decision-making process and access to learning; integration within the community to ensure full use of rights; recognition of the importance of fulfilling obligations; conveying a message of hope and dignity by the staff, based on the belief that each individual is equipped with the ability to learn and grow; enabling self-definition and empowerment; developing social networks for such individuals in their own communities and surroundings; promoting initiatives for support by colleagues and self-help groups; and attributing importance to the development of evidence-based practice together with innovative, promising practices as effective tools for promoting recovery processes. These principles focus on the accessibility and availability of the service, together with the holistic combination and coordination of the therapeutic services, and the individual’s interface with their various activities of daily living (United States Psychiatric Rehabilitation Association – USPRA).

The rehabilitation process is a personal one, which can be judged, first and foremost, by the individual himself/herself; and is not necessarily connected to a reduction in the psychiatric symptoms or a result of professional intervention. This is a long-term, multidimensional process, which constantly varies, and the idea of a personal process is an essential component, as is the involvement of that individual in managing the process (ISPRA – website; Lachman & Hadas-Lidor, 2008; Roe, et al. 2007).

The rehabilitation process is conducted by professional teams including treatment coordinators, social workers, psychologists, and therapists, as well as staff who are not required to have professional certification, such as rehabilitation counselors, or people with personal experience who work as supporters, or counselors, and group moderators. The rehabilitation process is supported by these teams in accordance with the individual’s needs at various points in time.

The professional guidelines that apply to these professionals are defined in the ethical codes and the legislation that regulates this field of activity, as well as in Ministry of Health regulations. Rules laid down in the ministry regulations apply to teams operating via service providers subject to outsourcing contracts with the Ministry of Health (David, 2020).[[2]](#footnote-2)

Since enactment of the Rehabilitation Law, the rehabilitation services have significantly expanded, and this field has become well established and developed. Nonetheless, there are a number of problems preventing the rehabilitation services from fulfilling their role in terms of integration within the community, as expressly stipulated in the purpose of the law. The number of people in need of this service is much greater than those who actually exercise their right to it. Although the group of those entitled to the service is extremely broad and includes some 115,000 who have been recognized by the National Insurance Institute as persons with a 40% level of psychosocial disability, which is a condition for eligibility to enter the rehabilitation services, the actual number of persons receiving rehabilitation services amounts to 30,000 (as of 2019). In fact, the State Comptroller has stated that, on average, only 50% of those eligible actually exercise their rights (David, 2020; State Comptroller, 2016). Many more do not even come within the bounds of the law, due to, among other reasons, the heavy stigma involved, bureaucratic barriers, the lack of accessibility of the process, and the requirement of recognition of 40% mental disability. The majority of applications for the rehabilitation basket are made a long time after an individual has already been coping with his/her state of mental health. The preconditions for entry into the rehabilitation program are complex. People who come into contact with the rehabilitation system suffer from prejudice that is very difficult to change. We have seen that the motivation for change is extremely low and the belief that a significant recovery process can be built requires much support. (Meidaos, 2021).

First, rehabilitation is a separate field to that of other community systems provided as part of the government social services. It neither strongly shares the professional medical approach in the Ministry of Health nor does it directly belong to the field of welfare but is located somewhere on the spectrum between the two of them. As there is no real integrative work between the systems in Israel, it is extremely difficulty to create a coordinated, integrative, community-based response. The explanation for this is rooted in the historical state structure of the provision of the services. From the very early days of the state, the welfare and education services have been provided at the local government level. While the health system was in part provided in the community via the HMOs, which acted as an extension of the Ministry of Health’s “long arm.” The mental health reform instituted in 2015 has not yet succeeded in combining between the provision of out-patient services connected on a spectrum and rehabilitation in the community. This problem weakens the integration within the community that many people need.

Second, there has been considerable budgetary erosion over the years. The population in Israel is constantly growing, the professional field has been making substantial headway, but the budgets have remained as they were at the time of enactment of the law (Aviram, 2019; Mark & Siegal, 2009). This clearly leads to erosion of manpower, and difficulty in developing new services and placing new focus on the services in the community.

Third, there is a lack of continuous treatment and rehabilitation. The system is organized according to discrete disciplines rather than systemically, so that somebody in need of assistance or who comes to the health services for help with an acute case, might receive help and guidance from the system in relation to the appropriate and relevant process for them, but this is accompanied by a lack of sufficient oversight of the overall course of treatment between hospitalization and rehabilitation in the community along with general realization of rights, as is required according to the Rehabilitation Law.

Fourth, the lack of tailoring of the services to unique populations and the division among the various government ministries impede the ability to facilitate tailor-made responses. For certain population groups, this division creates a lacuna in the field of mental health care, including: the elderly; children and youth; people with multiple disabilities; people with co-occurring disorders (mental health and addiction), and more.

An issue of critical importance for the system is the lack of resources and insufficient development of quality mental health manpower in general, and, in particular, in the field of rehabilitation. Clearly, it is impossible to implement any reform without the requisite manpower. There is an inherent lack of human resources within the system and many of the reforms that have occurred in Israel have not generated a change in the educational study content of the mental health professions, for example, social work, psychology, medicine and psychiatry – in parallel with the weakening trend of public psychology due to the lack of resources (Meidaos, 2021). The fact that the field of rehabilitation is organized via outsourcing also exposes it to contractual engagements that make it difficult to introduce changes, increase budgets, and support development.

An additional problem is the lack of adequate response for unique and vulnerable populations. There is a serious lack of programs designed to provide responses tailored for the needs of the especially vulnerable populations, such as the elderly, children and youth, people with co-occurring disorders, people who have suffered sexual abuse, and LGBTs. Although this field is beginning to develop, and interesting initiatives are being generated within it that create specially tailored responses, there is still no overall advanced approach of personally customized services, together with the relevant budget required to support such development.

**Current Mental Health Policy – The Need for Continuity of Treatment and Rehabilitation**

In October 2021, the Ministry of Health presented a strategic vision program designed to position the issue of mental health at the focus of the discussion, to fight stigma and grant those people with mental health concerns appropriate and timely conditions of treatment. Transferring the focus to the community was to be achieved by strengthening the community and expanding the clinic services; developing a community that genuinely provides benefit for people who have been in hospital all their lives; and considering integrating the psychiatric hospitals within the general hospitals. The emphasis in the program was placed on models of medical treatment and hospitalization in the community – shortening the waiting list for psychotherapy, taking people with SMI and its related intense healthcare needs out of hospitals; reinforcing the continuing treatment in the field of psychiatric hospitalization; clinic-based treatment and group homes that constitute an alternative to psychiatric hospitalization (Systemic Program for Mental Health, Ministry of Health, 2021; discussion at the Knesset Health Committee, October 12, 2021).

An examination of the program underscores the fact that the focus has in actuality been placed on psychiatric hospitalization and very little relates to the field of rehabilitation within the community. Although the term community does appear there, continuity of hospital care is the healthcare component that is emphasized on two levels. The first involves budgets for renovation of psychiatric hospitals, which clearly reflect the desire to strengthen psychiatric hospitalization within the recognized hospital system. The promise within the program is to incorporate these hospitals in the future within the general hospitals. The second level is that of alternative hospitalization services in the community, including home hospitalization, group homes, and rehabilitation communities, whose role is crucial in taking the severe, chronically ill out of the government hospital system. This approach is designed to bolster those models that focus on the continuity of hospital care as previously mentioned, rather than budgets for prevention, early treatment for the young and adolescents and rehabilitation in the community, and the requisite community integration for people with mental health concerns. This move appears to be connected to the Ministry of Health’s historical trend that is based on the field of conventional medicine and the majority of its resources are channeled into this (Aviram, 2019). Investing the best parts of strategy and development in hospitalization does not correspond with the trend of focusing the main effort on services in the community, and especially as a deeper scrutiny of the statistics reveal that those people in an acute state and who really need to be hospitalized are the minority within the overall group of those in need of mental support and the associated therapeutic and rehabilitation services. (Ministry of Health, 2020).

Within the trends that we have identified, it appears that community medicine is on the wane and becoming more and more of a digital service, and the face-to-face meeting between the patient and the physician is reduced to barely a few moments. As this approach to medicine refrains from in-depth treatment, we are now seeing more and more people requiring longer hospitalization, as they arrive at the hospital too late for more efficient interventions.

The mental health system in Israel does not currently contain sufficient preventive components to deal with the general population. The insurance reform might offer some degree of promise here, but the gap is still extremely large to be able to provide accessible and available mental health services to all residents across the country.

As far as continuity of care and rehabilitation is concerned, the access to appropriate and integrative rehabilitation-focused treatment is extremely limited. The load on the community clinics is also problematic when trying to prioritize the population in need of such services, and there is a lack of sufficient training for the professional practitioners in the clinical-treatment array who are able to provide supportive care for psychiatric rehabilitation, apart from drug-based treatment.

A number of factors have influenced the formulation of mental health policy over the years: bolstering the consumer organizations (patients and families) and their participation in the processes of change in terms of policy and practice; the growing strength of the human rights movements and their involvement in furthering mental health policy, and particularly Israel’s decision to become signatory to the International Convention on the Rights of Persons with Mental Disabilities that was ratified in 2012; increased media involvement and coverage of issues related to mental health in the community.

**The COVID-19 Pandemic Crisis in Israel and Rehabilitation in the Community**

Throughout its history, the State of Israel has always faced states of emergency, mainly emanating from security threats. The need to contend with significant, intense and often drawn-out emergencies, taking place within the civilian heart of the State of Israel, has called for well-oiled systemic organization of a number of entities, along with the optimal use of national resources. Over the course of time, various governments in Israel have made a number of decisions to regulate the issue of the responsibility and authority for dealing with the civilian home front during times of emergency and to improve its readiness for such eventualities. However, this has still not led to a complete and optimal solution, and numerous problems have repeatedly emerged both in terms of preparing the home front and actually dealing with it during times of emergency. One of the more substantial complex issues is the fact that those people with mental health issues are under the responsibility and supervision of the Ministry of Health, while the responsibility for dealing with special sectors of the population during times of emergency is that of the local authorities and the welfare services, which on many occasions neither recognize nor provide treatment for this special population during routine times (Sela & David, in the process of being published).

The global outbreak of the coronavirus created an entirely different reality. This situation, which was forced on the majority of the world’s population, included unusually extensive physical isolation and had a direct impact on the state of mental health of the general public. People, who prior to the current COVID-19 crisis experienced great mental difficulty or who were coping with mental disability, were found to be at a higher degree of risk for a deterioration in their mental state due to isolation (WHO, 2021). This was mainly due to the need for the overall fixed treatment and rehabilitation processes and the lack of personal interaction, combined with a shift from fixed routine patterns including sporting and social activity. The mental health community rehabilitation services include support of people in the process of recovery in a variety of walks of life. Usually, these services are provided almost exclusively on a face-to-face basis, via home visits, various group sessions, and coordination of treatment by a professional mental health specialist worker. The new reality that developed due to the COVID-19 pandemic forced many organizations to rethink how they could provide the various services, requiring serious systemic work to generate viable alternatives for the continued rehabilitation, therapeutic work (Sela & David, in the process of being published).

Following the outbreak of the coronavirus, the main challenge for the organizations was now how to provide stability and certainty for the recipients of the service and the professional staff in a situation of great uncertainty, as a result of the daily changing situation, the lockdowns, and mandatory isolation. As a result of the frequent changes in the regulations and guidelines, there was a need to make rapid decisions, changes in the working environment, together with a demand for continued support of the rehabilitation processes. Due to the need to maintain physical distancing and closely adhere to the Ministry of Health regulations relating to COVID-19, the Mental Health Division, Rehabilitation Department provided clear working guidelines, tailored for the employment, housing, and hostels services. The ability of those organizations providing rehabilitation services to pave the way for alternative services would not have been possible without the support and the ongoing instructions of the Ministry of Health’s Mental Health Division, Rehabilitation Department, both at the head office and in the various regions, which updated the instructions on a regular basis, made them accessible to the various service providers, maintained daily contact, and supported the opening of alternative frameworks to the existing rehabilitation services, along with the continued provision of the services by making the bureaucratic processes much more accessible (for example, conducting the rehabilitation basket committee hearings via video), etc. (Sela & David, in the process of being published; Ministry of Health guidelines during the COVID-19 pandemic).

On the one hand, the COVID-19 crisis underscored the importance of having the rehabilitation services operate under the central government, constantly issuing regulations by the Ministry of Health to keep pace with the developments and so that the instructions for operation of the services would be as clear as possible. On the other hand, the COVID-19 pandemic exposed the lack of organization across the entirety of the community welfare services and the extremely limited amount of integrated work. One of the issues that emerged quite clearly during the crisis was the lack of familiarity of people with mental health concerns with the welfare system, and, consequently, many resources did not reach those people who really needed them, so that the organizations providing rehabilitation services served as a social safety net for them (distribution of food, purchase of medications, assistance with obtaining pension allowances, and more.) (Hamilton et al., 2020). Throughout this challenging period, the government tried to promote round-table sessions as part of its efforts to encourage public participation, attended by representatives of the organizations of people with psychosocial disabilities, the various government ministries and authorities, the philanthropic foundations, etc. The objective of this effort was to create a dedicated platform to raise the issue of these barriers affecting people with disabilities (Report of the Sub-table on People with Disabilities during the COVID-19 Crisis, 2020).

As mentioned above, the 2015 insurance reform shifted the responsibility for the provision of treatment services to the HMOs in Israel. This was a significant move to make mental support much more accessible for every citizen in Israel. Even prior to the COVID-19 crisis, numerous issues arose regarding the lack of treatment services in the community, especially the growing needs of vulnerable sectors of the population that do not receive accessible and available responses (such as children, youth and young people, adults with multiple needs, and the elderly). It was clear that mental health needs really needed to be addressed as part of life in the community and for a long time, access to the mental health services was based on mistaken evaluation and insufficient resources. (Aviram, 2018).

חשוב לציין לפחות 3 גורמים שקמו במהלך השנים ומשפיעים רבות על שינוי במדינות וניסיון להעמיד את תחום בריאות הנפש על הרגליים:

1. חיזוק ארגוני צרכנים (מתמודדים ומשפחות) והשתתפותם בתהליכי שינוי במדיניות ופרקטיקה
2. חיזוק תנועות לזכויות אדם ומעורבותם בקידום המדיניות בתחום בריאות הנפש
3. מעורבות מוגברת של המדיה (טלוויזיה ועיתונאות) המלווים נושאים הקשורים לבריאות הנפש בקהילה וסוגיות קשות המתעוררים מדי פעם

**Rehabilitation – The Path Ahead and Requisite Reforms**

Mental health policy in Israel is beginning to assume a more central position within the public and political discourse in Israel. Policy makers understand that this is an area with a potentially significant impact on the state’s future growth and the State of Israel’s ability to meet international standards in relation to public spending on mental health services. The considerable, growing exposure to the field of integrating people with psychosocial disabilities in the community now calls for renewed thinking on the related resources and their distribution, both due to the importance of this issue and the need to comply with the provisions of the International Convention on the Rights of Persons with Disabilities (CRPD). The State of Israel has made progress and introduced a reform to reduce the amount of hospitalization in Israel, a reform to establish rehabilitation services in the community for people living with mental health problems, and the insurance reform, which are by no means without any difficulty. Nonetheless, they **constitute the basis of a significant catalyst to strengthen the overall mental health system, and in our opinion, now is the time to move ahead with a community reform**. Such a reform needs to be based on preventive mental health services and community-based work to reduce public stigmas in relation to mental disability and mental disorders. In parallel with increasing the requisite level of public expenditure for mental health as a whole, it is important to bolster and increase the resources for services in the community, and thus to affect a shift in momentum and reform the two key parts of this field: prevention and rehabilitation.

An effort is required to expand the accessibility and availability of the services in the community and to bolster treatment models and services that do not reinforce stigma but contend with it, as well as reducing the entry barriers into the system.

The interface between the various services needs to be shored up, in order to further continuity of care and boost the responses given to an individual based on specific needs when dealing with various government ministries, especially for people coping with complex needs.

One of the solutions is to bolster treatment coordination.

It is also important to expand the efforts to measure and study the impact of these responses to mental health needs. Such measurement is usually based on the medical psychiatry model that includes quantifying the number of people admitted for psychiatric hospitalization along with the duration of their hospital stay. However, when formulating mental health policy, it is actually no less important to establish the models on criteria that examine additional elements such as independence, ability to cope and lead an independent life via a variety of personally tailored practices.

[מדדי תוצאה – נכנסו מדדים שונים2 - מאמרים של מקס (כלכלן משוויץ; הקושי במדיניות כלכלית בבריאות הנפש]

This investment must be based on the development of professional staff and the reinforcement of the community-based peer-support groups, as well as recognition of this field as a professional sphere. People living with SMI are in real need of ongoing, stable and humane support. There is a need for policy that supports the creation of this link and prevents too much staff turnover; thus, enabling the minimal conditions for the therapists and caregivers. The wages of social workers and their professional promotion paths are also a requisite component of such an effort.

אין אוריינטציה בתוך תחום בריאות הנפש של פרקטיקה שהיא מול הקהילה כפציינט. מהי עבודה קהילתית מעבודה סוציאלית ולראות איך זה יכול להיות בתוך תחום השיקום הקהילתי. [חומרים על עבודה סוציאלית קהילתית]

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2. See ethical codes of therapeutic professions, Ministry of Health Director General Guidelines for Rehabilitation: Ministry of Health Director General Guideline 80.001 “Hostel services - standards and service operation regulations” (September 1, 2009), Ministry of Health Director General Guideline 80.002 “Sheltered accommodation - standards and service operation regulations” (September 1, 2009), Ministry of Health Director General Guideline 80.003 “Sheltered (rehab) facility: standards and service operation regulations” (September 1, 2009), Ministry of Health Director General Guideline 81.005 “Sheltered (rehab) facility: standards and service operation regulations” (September 1, 2009), Ministry of Health Director General Guideline 82.002 “Social club: standards and service operation regulations” (September 1, 2009), Ministry of Health Director General Guideline 80.050 “Opening and closure of rehabilitation framework regulation” (January 1, 2006), Ministry of Health Director General Guideline 88.001 “Community rehabilitation program management service” (January 1, 2004), Ministry of Health Director General Guideline 81.005 “Financial auditing in rehabilitation frameworks” (September 1, 2011); Ministry of Health Director General Guideline 75.004.01 “Regulation for treatment of public inquiries/complaints in the rehabilitation system” (October 1, 2015); Ministry of Health Director General Guideline 85.001 “Regulation for treating an unusual incident in the rehabilitation services” (February 1, 2016). [www.health.gov.il/UnitsOffice/HD/MHealth/mental/Pages/regulations.asp](http://www.health.gov.il/UnitsOffice/HD/MHealth/mental/Pages/regulations.asp) [↑](#footnote-ref-2)