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THE LAW FOR REHABILIATION IN THE COMMUNITY OF PERSONS WITH MENTAL DISABILITIES: AN INTERIM APPRAISAL

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The Law for Rehabilitation in the Community of Persons with Mental Disabilities
An Interim Appraisal

Uri Aviram*

Abstract

The purpose of this chapter is to present the Mental Health Rehabilitation Reform, and to analyze the challenges it faces at the start of the second decade of its implementation. Besides reviewing the reform's accomplishments and its contribution to the changes that have occurred in mental health services, the article also assesses the dangers it has to contend with. The analysis focuses on the system's clients, budget, personnel, and services – and on its functional environment. In the course of the decade, the mental health rehabilitation services have considerably expanded, resulting in significant savings to the state; nevertheless, rehabilitation services cover only about one-fifth of the target population and many of those entitled to a rehabilitation service package fail to secure it. It also bears mention that there has been erosion in the average budget per rehabilitation recipient. In order for the reform

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to achieve its objectives, the services and budget must be adapted to the changing character of the mentally disabled, as well as to the special needs of specific population groups. Such problems as the quality and training of personnel in the rehabilitation network and market failure and loss of control by the regulators over a system should be dealt with and avoided. Lastly, the chapter discusses the mutual dependency between the rehabilitation service system and the Insurance Reform, due to start in 2015, emphasizing the importance of the rehabilitation system's efficient and effective functioning to the success of that reform and to improvement of the mental health services in general.

The Rehabilitation in the Community of Persons with Mental Disabilities Law was enacted in 2000 and first budgeted in 2001. This important social law is based on innovative approaches for the rehabilitation in the community of persons with serious mental illness and their integration in society, and is considered one of the most advanced of its kind in the world (Aviram, 2011; Drake, Hogan, Slade, and Thornicroft, 2011). Already in the first decade of the law's implementation, there have been dramatic changes in the field of rehabilitation of psychiatrically disabled persons in the community.

The rehabilitation reform is a significant component in the State of Israel's attempt to shift the locus of treatment and care from psychiatric hospitals to the community – an attempt that began four decades ago (Aviram, 2007). The aims of the reform were to integrate mental health services with general healthcare, to improve the quality of service, and to make it more efficient. To a large extent the reform can be credited with several changes in the system of mental health services in Israel, such as the dramatic drop in the rates of psychiatric beds per the general population and shortening of the average psychiatric hospital stay (Aviram, 2012).

Persons with mental disorders are extremely handicapped from medical, functional, and social aspects. The incidence of physical disease among them is higher than among those who do not suffer from mental illness, and their mortality rate is much higher than among their age cohort in the general population (Weinberger, Wiener, and Leor, 2008). The World Health Organization has ranked mental illness alongside heart disease and malignant diseases on the scale of Global Burden of Disease, and they are among the ten leading causes of disability in the world (Murray and Lopez, 1996). Furthermore, the rate of those married and those formerly married (which can serve as a measure of the level of social support) and the labor market participation rates among individuals with mental illness are low in comparison to other populations that receive National Insurance Institute disability allowances (Pinto, 2012). This population suffers from poverty and social stigma and exclusion as well (President's New Freedom Commission, 2003).

The overall outlay imposed on society because of mental illness and its economic consequences have yet to be measured in Israel. That expenditure far exceeds the government budget devoted to mental health services, which today amounts to about NIS 2 billion. To that must be added, among other things, the health fund (Kupat Holim – similar to HMOs) budgets devoted to mental health, the disability allowances provided to about 70,000 individuals with mental illness by the National Insurance Institute, the funds devoted by local authorities, the housing support provided by the Ministry of Housing, and the not inconsiderable sums paid for treatments through the private sector (Shamir, 2006). The economic burden on families caring for the mentally disabled due to the loss of workdays and other expenses must be taken into account, along with the mental and economic costs of the higher incidence of disease among caretaker families (Gallagher and Mechanic, 1996). On the basis of an estimate of the social and economic costs of mental illnesses in Britain (The Sainsbury Centre, 2003), adjusted to the population size and standard of living in Israel (according to gross domestic product, or GDP), the annual cost of mental illnesses to Israeli society reaches

$13 billion. The rehabilitation of individuals with mental illness and their integration in the labor market can save society considerable sums, in addition to the personal benefit to the individuals and the improvement in their quality of life. In this matter, too, no proper estimate has been conducted in Israel. However, in accordance with the results of a study by Kessler et al. (2008) in the United States (adjusted to the population size and GDP in Israel), the loss to gross domestic product due to the non-employment of those with mental illness in Israel is estimated at $2.5 billion a year. Although these estimates may be imprecise, they undoubtedly highlight the social and economic benefits to be gained by contending properly with mental illnesses and rehabilitating these individuals in the community.

1. The Rehabilitation in the Community of Persons with Mental Disabilities Law

The Rehabilitation in the Community of Persons with Mental Disabilities Law (2000; hereinafter: the Rehabilitation Law) is based on two principles:

A. Individuals suffering from disability due to mental illness are entitled to rehabilitation.

B. The rehabilitation services package allocated to persons with mental disabilities will be based on professional judgment.

The law also states that the rehabilitation services package is provided on the basis of a personalized rehabilitation plan, one that places the individual and her/his aspirations at the focus.

Anyone aged 18 or above that is found to have a mental illness following a psychiatrist examination and determined to suffer from at least 40 percent medical disability according to National Insurance Institute criteria is entitled to request rehabilitation services from the regional rehabilitation committee. The rehabilitation committee, which is

comprised of professionals in the rehabilitation field, examines the individual's needs and allocates rehabilitation services out of the rehabilitation basket of services set by law. The basket includes vital rehabilitation services ranging from sheltered housing, occupational rehabilitation services, completion of education and social activities for leisure hours, to dental care, assistance to families of those with mental illness, and treatment management services.

According to the law, the basket is determined by the Minister of Health in consultation with the Minister of Finance. The legislature, in its desire to ensure that the implementation authority would not be able to make changes in the composition of the basket by itself, determined that any change requires confirmation by the Knesset's Labor, Welfare and Health Committee (Rehabilitation Law, 2000).

Much can be learned from the process that led to the law's enactment, not only about reforms in the field of mental health, but also about reforms in the field of health and welfare in general. The present chapter will not expand on the topic, since the factors and circumstances leading to the law's enactment have been discussed at length elsewhere (e.g., Aviram, 2012; Elizur et al., 2004; Haver et al., 2006; Shershevsky, 2006). However, it bears mention that its enactment stemmed from a combination of factors, including the leadership and determination of a group of people headed by then-Knesset member Tamar Gozansky, seizing of opportunity and cooperation by the administrative establishment in the Ministry of Health, support (albeit qualified and conditional, but vital) of the Ministry of Finance, and special circumstances that at the time enabled the legislation of privately proposed laws of such a financial scope. That possibility has since been made impossible due to the enactment of the Arrangements Law passed in 2002 and 2003.

The Law's Target Population

Although the law clearly describes the entitled population, defining, locating, and measuring the distribution of mental illness in the population is far from simple. Issues related to defining mental illness, its psychiatric diagnosis and validation, and the epidemiology of mental illness have already been discussed at length in the literature (e.g., Mechanic, McAlpine and Rochefort, 2013), and there is no need to reiterate them here.

According to the National Insurance Institute's 2012 figures, the number of those receiving a disability allowance due to psychiatric diagnoses totaled about 70,000 at the end of 2011. This figure underestimates the total target population as it includes only those who have applied to the committees and have not only met the criterion of medical disability, but have been classified as having lost the ability to earn a livelihood.

The group of individuals with mental illness comprises one-third of the recipients of disability allowances, and is the largest category. It is also the largest group that receives transfer payments of 75 percent and above the maximum disability allowance.

According to various estimates, it can be concluded that the number of people in Israel suffering from serious and prolonged mental illness currently totals about 100,000 (Aviram, Zilber, Lerner, and Popper, 1998; Struch, Shershevsky, Naon, Daniel, and Fischman, 2009). This is the main target population of the rehabilitation services. Close family members who care for the mentally disabled must be added to this, since the physical, mental, and economic burden of treating and caring for a family member suffering from mental illness is great (Gallagher and Mechanic, 1996). According to the estimates of the Central Bureau of Statistics (CBS), the number of mentally disabled and close family members caring for them totals about 350,000, equivalent to the population of a medium-sized Israeli city.

2. The Rehabilitation Reform and Structural Changes in Mental Health Services Over the Last Decade

In the Rehabilitation Law's first decade of implementation, there were already dramatic changes in the rehabilitation services designated for persons with mental disabilities. According to the figures of the Ministry of Health (2001, 2008, and 2013), the number of people with mental disability who receive rehabilitation services grew from 4,000 in 1999 to 16,000 in 2009, and is currently approaching 20,000 (as reported by the head of the mental health rehabilitation services of the Ministry of Health). The rehabilitation services are delivered through about 600 different programs, all of them provided by not-for-profit organizations (NGOs) and private entrepreneurs. The government budget for the rehabilitation of the mentally disabled in the community has grown eight-fold (in fixed prices) and currently totals about half a billion shekels. The rehabilitation budget's share of the overall mental health budget, which at the start of the period was less than 4 percent, reached one-quarter by the end of the first decade of the law's implementation (Aviram, Ginath, and Roe, 2012).

The rehabilitation reform was one of the main factors enabling the dramatic changes that occurred in the hospitalization system. In the decade from 1999 to 2009, the number of psychiatric beds dropped by 50 percent. The yearly number of days spent in hospital at the end of the period was 43 percent lower than at the beginning. The average hospital stay was significantly shortened, the share of long-term hospitalizations fell appreciably, and the duration of stay in the community of those released from hospital before needing to be hospitalized again lengthened on average substantially (Aviram, 2010b, 2012; CBS, 2002, 2011; Hornik-Lurie, Zilber, and Lerner, 2012; Ministry of Health, 2002, 2009, 2013).

Without diminishing from the significance of the changes brought about by the so-called “structural reform,” analysis of the data reveals some disturbing facts. As opposed to other countries that implemented mental health reforms, where the reduction in the number of psychiatric beds was accompanied by the closing of government hospitals for the mentally ill (see, e.g., Goodwin, 1997; Mechanic and Rochefort, 1990), not even one government hospital was closed in Israel. Furthermore, most of the reduction in the number of psychiatric beds in Israel stemmed from a reduction in the number of beds in private (for profit) hospitals and from the closing of some of those hospitals.

It bears mention that a considerable share of the beds in private hospitals that were ostensibly eliminated were actually converted and defined as treatment residences and intensive treatment residences – as happened in the United States, where alternative beds were opened in various nursing facilities instead of beds being eliminated in psychiatric institutions (Lerman, 1982; Segal and Aviram, 1978). In Israel, this phenomenon of converting beds to treatment residences occurred not only because it was impossible to rehabilitate the population that had been committed to private hospitals who were seriously handicapped in terms of a community framework, but also because the government wanted to change the financing arrangements to make caring for this population cheaper, which was realized through a reclassification of the beds. In most cases, the beds even stayed in the same facility, and only their categorization changed.

The processes that transpired in the framework of the structural reform and the rehabilitation reform also aligned with the government’s policy of reducing the personnel employed by the government and cutting costs. The figures in the state budget proposals for the decade 1999-2009 show that whereas the number of employees in the Ministry of Health rose during the course of the decade, the number of employees in mental health services dropped by about 10 percent during the same period. These changes also led to substantial savings in treatment costs, since the average cost of a one-day hospital stay in treatment residences or a

one-day stay in sheltered residences in the community is much lower than the cost of a stay in government or private hospitals for the mentally disabled.

A common argument, especially among Ministry of Finance officials, is that the allocation for rehabilitation is "new money," i.e., an addition to the budget above and beyond what was previously allocated to mental health services. But closer scrutiny of budgetary trends reveals that this argument has no basis in fact. Indeed, the budgetary section allocated in the mental health services for rehabilitation services and the monies that have flowed to these services were new. Generally, however, not only has the state not added any money to the mental health budget, but it has also saved considerable sums over the past decade since the law's implementation. Without the rehabilitation services, especially the various sheltered residences, it would not have been possible to reduce the number of hospitalized patients significantly – and due to their high cost, the state would have had to spend at least another NIS 1 billion beyond the so called "new funds" that it invested in rehabilitation services in the community (Aviram, Ginath, and Roe, 2012). The implication is that the state did not use all the money that it saved due to the reduction in hospital stays towards the benefit of rehabilitation services for the mentally disabled in the community.

3. The Rehabilitation Law's Second Decade of Implementation: Challenges and Opportunities

In examining the challenges that face those responsible for implementing the Rehabilitation Law, reference should be made to the critical elements that define the system: the target population, the financial sources for the rehabilitation network's operation, the personnel devoted to its operation, the organization of the operating system, and the tools and services at its disposal by law. Since the actual operation of the rehabilitation network is influenced by and even dependent on its functional environment,

i.e., the organizations and interested parties impacting the rehabilitation network, they must also be taken into account.

The Attempt to Change the Rehabilitation Law

The uniqueness of the Rehabilitation Law and, to no small extent its power as well, stems from the fact that it is anchored in legislation. A change to the law is liable to seriously damage it, and the Ministry of Finance seems likely to pursue such a change.

Towards the end of the first decade of the Rehabilitation Law's implementation, when the government tried to complete the legislation for the Insurance Reform in mental health – which transfers responsibility for mental health inpatient and ambulatory services over to the health funds – an attempt was made to change the Rehabilitation Law and in effect uproot one of its foundations. The Ministry of Finance conditioned its support for the insurance reform in mental health services on the introduction of an article in the proposed law which, among other things, was intended to restrict entitlement to rehabilitation services and place them under a budgetary limit – i.e., set a maximum sum to be allocated to the rehabilitation package regardless of the number of those entitled to rehabilitation services according to medical criteria.

In general, throughout the decade, the Ministry of Finance was concerned about the budgetary ramifications of the entitlements granted by the Rehabilitation Law. Although the government recently abandoned its attempt to pass the insurance reform through legislation and, instead, approved it by administrative order in 2012 without the article that changes the Rehabilitation Law, the danger to the law has not disappeared. The Ministry of Finance, in its desire to control the state's budgetary commitments, may repeat its attempt to change the Rehabilitation Law, either by means of legislation or by administrative and budgetary means, as detailed below.

Target Population

At the end of the law's first decade of implementation, it emerged that the rehabilitation network was far from serving the majority of the potential population to be rehabilitated. Figures of the *Mental Health in Israel: Annual Statistical Reports* published in 2013 show that the number of people who received a rehabilitation package at the end of 2010 amounted to only 15-20 percent of the estimated population entitled to rehabilitation services. Even if it is taken into consideration that only some of those potentially entitled will want to receive a rehabilitation package, this still means that most of the entitled population remains outside the circle of those benefiting from the law.

The Ministries of Health and Finance have planned for a maximum of 22,000 individuals in rehabilitation (when the system reaches a steady state) which does not align with even the most conservative estimates of 100,000 by experts familiar with the actual situation. Undoubtedly, one of the challenges facing the system is to increase the number of entitled mentally disabled persons that actually receive rehabilitation services, and also to take into account the changes required in planning and resource allocation due to the demographic increase of the general population.

In addition to the number of those in rehabilitation, characteristics of the rehabilitation network's target population demands attention as well. Whereas the first wave of individuals in rehabilitation included many who had been released from psychiatric hospitals after prolonged periods of hospitalization, today many of the applicants are young people at the start of what is called their "psychiatric career." The problems and needs of this population differ from those of the mentally disabled in rehabilitation who were released from institutions after prolonged hospitalization. The professional literature makes it clear that the rehabilitation intervention methods are quite different from those for populations at the beginning of the process, and that the costs of treatment and rehabilitation for the current population are higher than those of the first wave.

Any planning of the rehabilitation network must take into account specific population sectors and distinct age groups, relying on knowledge of such topics as morbidity rates, the nature of illnesses and disabilities, as well as the characteristics of this population group. The system will also have to devote special attention to the geriatric population, among whom the rate of those suffering from mental disability is higher than among younger age groups.

Budgets

As explained previously, in the law's first decade of implementation the rehabilitation budgets grew impressively, and their share of the overall mental health services budget grew as well. These changes may be misleading, however, because at the start of the period the allocation for rehabilitation was minimal, and also because it does not mean that the funds allocated to establishing and developing the rehabilitation network conform to the requirements of the law and the needs of the system. Furthermore, in the original planning, the legislature assumed that budgets for rehabilitation would grow also through the pooling of budgets from other sources. What in fact has happened is that local authorities that previously provided services to individuals with mental disabilities in the framework of their social services budget, now refer the needy to the rehabilitation network and have stopped allocating funds from their own budgets.

Whereas during the law's first five years of implementation, in accordance with the agreement between the Ministry of Finance and the Ministry of Health (2001), the rehabilitation services budget was based on a multi-year plan, since 2006 the budget has been based on yearly additions determined by annual (and lately even biannual) negotiations. Even the State Comptroller, in his Annual Reports for 2009-2010, took note of this, stating that the principles according to which the budget is updated annually are unclear and not based on multi-year planning that is open to professional and public scrutiny.

Since it has been estimated that the population receiving rehabilitation services is only one-fifth of the population entitled to the rehabilitation package, the budget should make it possible to increase the share of those in rehabilitation until at least 50 percent of the target population is reached. Furthermore, the budget has to reflect demographic growth and the changes in the character of this population, as well as special problems of the geographic and social periphery. All of these necessitate increasing the average budget per person in rehabilitation services. However, analysis of the government budget for rehabilitation for the second half of the law's first decade of implementation indicates that as opposed to what is needed, and despite the expected increase in the number of individuals in rehabilitation, the average budget per person has shrunk and is far from meeting the system's needs satisfactorily.

Housing services are a central and vital component of the rehabilitation package. As emerges from the data of the *Mental Health in Israel: Annual Statistical Report* for 2013, about 60 percent of rehabilitation package recipients are awarded sheltered housing. Likewise, most individuals with mental illness living in sheltered housing also receive a rent subsidy from the Ministry of Housing. However, due to the relatively low level of the subsidy for housing and the low disability allowance that most mentally disabled people receive from the National Insurance Institute, many are unable to find housing in the location of their choice and near their family members. In addition, they often find it difficult to move to less intensive, less restrictive sheltered housing arrangements (as their mental conditions allow), because of the additional expense. These factors compel many of those in rehabilitation to seek housing in the periphery and in the social and geographic margins. This situation is liable to give rise to "ghettos" of mentally ill persons, as has happened elsewhere in the world (Aviram and Segal, 1973; Isaac and Armat, 1990), infringing on their rights, and harming their quality of life and their rehabilitation in general.

One of the reasons for the damage to the quality of rehabilitation is the unrealistic pricing in the tenders for rehabilitation services. Without reasonable pricing, many potential entrepreneur service providers avoid participating in the tenders. This leads to the reduction or absence of competition among potential service providers and results in the government's dependence on a few providers – who themselves are forced to reduce the quality of their service so as not to lose money – since the government must be in compliance with the law and ensure rehabilitation services.

In light of all this, the topic must be reexamined and the budgets set in a way that allows high quality standards for service providers and enables real competition. At the same time, proper supervision and oversight must be ensured while preventing market failures, which would be harmful to the quality of the rehabilitation services and infringe on the target population's rights.

No discussion on matters relating to the rehabilitation services budget can be concluded without referring to the Insurance Reform in mental health, which is planned for implementation in 2015.

The Insurance Reform in Mental Health and Budgeting of Rehabilitation Services in the Community

The Insurance Reform, i.e., transfer of responsibility for mental health ambulatory and inpatient services to the health funds, is meant to lead to an improvement in services, bring down the number and duration of hospitalizations, and increase the demand for rehabilitation services in the community among those entitled who have not yet received the necessary services. However, if the rehabilitation services are unable to adequately address the situation, the Insurance Reform is unlikely to succeed. Was the growing need for rehabilitation services taken into account when the Insurance Reform was planned?

The Insurance Reform is also meant to improve the mechanism for the budgeting of mental health services. A Supreme Court ruling from

June 21, 2012 determined that the standards in light of which the health funds' budget is updated need to be changed, and the state is supposed to improve the mechanism for determining the budget channeled to the health funds and in effect increase it. The question that should worry all those concerned about the level of mental health services is whether these changes will also be reflected in a real increase in the budget channeled to mental health services.

There is no certainty that all the moneys channeled to the health funds for the purpose of accommodating mental health services will, indeed, be put to that use, since the moneys channeled to the health funds are not earmarked for specific fields (e.g., mental health) and their use is at the health funds' discretion. Due to competition among the health funds over services in various fields, there is a danger that some of the mental health money will be diverted to other services that are more attractive to the funds' insured clients, to other fields of expertise, and to stronger lobbies. In light of this, the state must ensure that at least in the initial period – for a decade or two after the reform, until the mental health services are stabilized and have an opportunity to develop a powerful professional, administrative, and public lobby – the funds meant for mental health are earmarked, and there is supervision over how they are spent. It may be assumed that an improvement in ambulatory and hospitalization services in the wake of the reform may also improve the rehabilitation services in the community.

Since the rehabilitation services remain the state's responsibility, it must be ensured that they are updated taking into consideration demographic changes, price rises in the economy, and additional moneys required due to innovations in proven intervention technologies, as well as the special needs of specific populations in the state's social and geographical periphery.

Personnel

The personnel operating the services are a vital component that determines their quality, and even a measure of the level of the implementation of the law itself. The State Comptroller, in reference to the deployment of personnel in the course of the Rehabilitation Law's first decade of implementation in his reports for 2007 and 2010, noted that the personnel that administer the services, operate the rehabilitation committees, and are involved in supervision, monitoring and control of the services are far from sufficient to run the rehabilitation network properly.

Since most of the system of services is operated by private service providers, and in the absence of government requirements for high-level professional personnel to operate the services, it is not surprising that the personnel are often not of the professional level required to perform rehabilitation tasks. Importantly, in order to change the situation the state must insert stricter requirements for suitable manpower in its tenders, with all that entails from a budgetary aspect.

In light of the fact that the rehabilitation of individuals with mental illness is a relatively young field, it is necessary to develop programs for training personnel, either in the framework of the effort to develop a profession devoted to dealing with mental health community rehabilitation (Roe et al., 2011), or in the framework of existing professions. The effort to develop appropriate professional training, both at the academic level and in the framework of various programs that do not lead to an academic degree, must be accelerated.

In this matter, the importance of training the disabled, and of course employing them, bears emphasis. Although in the course of the last decade not insignificant efforts were made in this field, and there have been some notable accomplishments (Dudai and Hadas-Lidor, 2009), the situation is still far from ideal, especially with respect to the employment of people suffering from psychiatric disability in the free market.

Services

Since the Rehabilitation in the Community of the Mentally Disabled Law was designed in the Knesset in the 1990s, the rehabilitation basket has not been evaluated, nor have any changes been introduced into it. Such decisions need to be made on the basis of empirical evaluations of the existing basket, accumulated knowledge on the topic from Israel and around the world, as well as defined budgetary considerations and priorities. Importantly, although determining priorities needs to be based on knowledge, it also involves social considerations and demands public debate with the participation of experts, professionals in the field, legislators and, of course, the family members and the disabled themselves.

Several issues have emerged already in the law's first decade of implementation as requiring attention, including the "hostelization" phenomenon: the difficulties in moving to less restrictive housing in the community that the mentally disabled encounter; problems in the assertion of their rights and choice of services; the low rate of rehabilitation in the Arab Israeli sector; the long waiting period for housing solutions, low rent subsidy rate, and lack of choice in certain areas; an absence of suitable regard for and cultural sensitivity toward special populations; flaws in continuing ambulatory treatment after hospitalization, and in the coordination between clinical and rehabilitative systems; partial and insufficient coverage of case-management services; and difficulties of occupational and employment solutions in the framework of the free market. Additionally, opportunities must be widened for individuals who are studying to complete their undergraduate academic degrees, and for youth below the age of 18 to complete their education.

As emerges from data published by the mental health services, which also appeared in the State Comptroller's Reports, one of the topics requiring immediate attention is the fact that many individuals do not avail themselves of the rehabilitation package allocated to them. On the basis of analyses that were conducted, between one-quarter and one-third

of those for whom a rehabilitation package was approved do not avail themselves of even a single component of the rehabilitation services allocated to them, and many others avail themselves of only part of the basket of services. The reason for this may be problems in the service allocation processes and the personnel responsible for services, and the topic must undoubtedly be examined.

Since the various elements of the mental health services system are interconnected, the rehabilitation network is dependent on the functioning of the inpatient and ambulatory systems, as well as on the health system and the social services. The ongoing adverse effect of the continuous budgetary reductions of the community clinic system (Aviram, 2010) and lack of efficient cooperation with physical healthcare, the clinical mental health network, and local welfare services will no doubt have negative consequences for the functioning of rehabilitation in the community and damage its ability to fulfill its intended role. The Insurance Reform, due to come into effect in 2015, is supposed to correct this situation, but it is still too early to say whether the change will actually occur.

Rehabilitation in the Community of Persons with Mental Disabilities and the Upcoming Insurance Reform in Mental Health

The major problem the Rehabilitation Reform will have to contend with during the implementation of the Insurance Reform stems from the fact that while the mental health inpatient and ambulatory services are being transferred to the responsibility of the health funds, the rehabilitation services will remain the state's responsibility. The health funds will have a therapeutic and financial incentive to transfer anyone suitable for rehabilitation in the community to the government rehabilitation network, but that network will depend on the government budget and other authorities with regard to its ability to provide the required services. On the other hand, the efficient functioning of ambulatory and inpatient services, especially the coordination required between the clinical

services and the rehabilitation services to ensure continuity and quality of treatment and care, will not be under the government's complete and efficient control. The rehabilitation network, then, will be caught between opposing organizational and budgetary forces, and its functional environment (i.e., the organizations and existing networks which interact with it and influence its functioning) will have interests that do not necessarily align with or contribute to the proper functioning of the rehabilitation network.

4. Summary

The achievements of the Rehabilitation Reform in its first decade of implementation are indeed impressive, but its continued success is not to be taken for granted. This chapter has noted quite a few problems and issues that require attention. The flaws and problems must be examined, the services rendered must be evaluated, the manner in which they are supplied and their outcomes must be reviewed, and action must be taken to correct problems. In this matter, of prime importance is the development of an information network to enable monitoring, control, and outcomes evaluation. Despite repeated declarations by the mental health services and the Ministries of Health and Finance regarding the importance that the government attributes to evidence-based research on the results of rehabilitation, to date very little has been done in this field.

Evaluation research on rehabilitation processes and their outcomes are important not only from professional and budgetary perspectives, but from the public perspective as well. They are important for strengthening the public legitimacy of the field, which is especially vital in light of the powerlessness of the population on behalf of which the Rehabilitation Law was enacted. As such, it would be worthwhile to adopt the arrangement pertaining to the National Health Insurance Law, according to which a certain percentage of the budget is devoted to research and evaluation. The allocation should be anchored in legislation, or at least in

an administrative arrangement. Likewise, it is important to determine priorities for research and evaluation, and to ensure that the funds are allocated to researchers in a manner not dependent on the operational system, but rather on the basis of absolutely independent scientific evaluation.

Another topic that deserves careful scrutiny is the question of the rehabilitation system's position within the government ministries: should it remain the responsibility of the Ministry of Health, or be transferred, for example, to the Ministry of Social Welfare and Social Services? This is one of the tasks the government will have to contend with in the law's second decade of implementation and in light of the implementation of the Insurance Reform, and it is important that this examination be guided by professional and organizational considerations.

As noted in this chapter, the efficient and beneficial functioning of the mental health system is of great importance not only with regards to the rehabilitation and quality of life for the system's users, i.e., the disabled and their family members, but also from a social and economic perspective. This field should benefit from the improvement in the standard of living in Israel, like other fields in society. The data may show that the government budget for mental health indeed did not change substantially and was not adjusted to reflect improvement in the economy in the last decade, but, as noted by Chernichovsky and Regev in this report ("Trends in Israel's Healthcare System"), overall public healthcare spending still fell far short of reflecting GDP growth and the rise in standard of living in Israel, nor did it correspond to improvements in other social service areas during the same period.

Although some of these problems can be fixed with the help of the body that performs the rehabilitation itself, a considerable share is dependent on other systems and factors over which the rehabilitation network has no control. In the wake of changes that have occurred since the Rehabilitation Law was enacted, cracks have appeared in the coalition supporting the law. The Ministry of Finance, which was vital to the success of the law at the start of its implementation, is now seeking to

restrict it, either through legislation or by budgetary means. The frequent postponements of the implementation of the Insurance Reform in mental health since the late 1990s and the ongoing attrition of ambulatory services may also damage the rehabilitation network. Additionally, of course, there is great uncertainty regarding the final implementation in two years' time of the Insurance Reform and how this will affect the Rehabilitation Reform.

Regrettably, the topic of mental health, including the rehabilitation of individuals with mental illness in the community, is at the margins of public interest. The fact that it concerns a powerless population, which suffers from stigmatization and social exclusion, impacts that population's ability to influence any change of policy. A weighty moral and professional responsibility therefore lies on the shoulders of the professionals who treat this population and those social agents, few as they may be, who are concerned about the mentally disabled and their quality of life. An effort must be made to organize a political and public lobby, and with the help of the disabled and their family members, to place the topic on the public agenda and take action to preserve, develop, and advance the rehabilitation reform. This will undoubtedly have consequences for the future implementation of the Insurance Reform, and ultimately for the usefulness, significance and quality of all mental health services in Israel.

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