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Mental health Policy and Programs in Israel: Trends and Problems of a Developing System

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Israel has an ancient history blended together with a relatively brief independent identity. An introductory section provides a backdrop for understanding mental health policies and programs in the context of the cultural and historical background of Israel's people. The second section portrays the nature of the mental health delivery system. The final section focuses on three interrelated issues: the limited development of community mental health services, the dominance of the mental hospital in the provision of mental health services, and the medicalization of mental health services.

Israel mental health policy and services reflect the country and the people they serve. Although Israel gained its independence only forty years ago, it is a state of people with an ancient history. Understanding the current problems and continuing issues of the country's mental health services cannot be done without taking into account the political and social conditions of the country as well as the historical and cultural background of its people.

There are about 7000 patients hospitalized in 38 psychiatric inpatient facilities in the country. More than 11,000 admissions per year have been reported by these facilities. Mentally ill people occupy more than one-fourth of the total number of inpatient beds in the country (Central Bureau of Statistics, 1989; Israel Ministry of Finance, 1989). An estimated 650,000 psychiatric patient care contacts take place each year in about 60

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outpatient mental health services (Mental Health Services, 1986; Siegel et al., 1989; Ministry of Health, 1989). There are about 90 other mental health services in the community, such as day care units, social clubs, sheltered housing and rehabilitation services (Popper & Rahav, 1984; Ministry of Health, 1989). Mental health services are allocated a substantial part of the state's health budget. Although mental health services have not been at the top priority list of public agenda, these services and the condition of the mentally ill have drawn public attention. The disability and vulnerability of the mentally ill and the quality of services provided for them have been, from time to time, a cause for public concern.

The purpose of this paper is to describe the mental health policies and programs of Israel and to analyze the major issues they face in light of the current problems of the country, its history and the cultural background of its people. Some of the problems of the mental health service delivery system stem from organizational and financial difficulties, while others reflect deeply embedded structural factors.

The paper has three major parts: I. Introduction, II. Israel Mental Health Delivery System, and III. Current Issues and Continuing Problems. The Introduction includes a short description of the country and its people, and a brief history of mental health policies and services. The second part which focuses on describing the mental health service delivery system starts with a discussion of epidemiological data revealing recent trends in mental health services. It follows with analyses of institutional care, community services and psychiatric rehabilitation programs. This part is concluded by a section on budgetary and personnel issues and touches upon disability and income maintenance legislation and programs pertinent to mentally ill persons. Finally, in the third part of this paper, three interrelated issues of the mental health system will be addressed: the limited development of community mental health services, the dominance of the mental hospital in the provision and administration of mental health services in the country, and the medicalization of mental health services.

I. Introduction

The Country

Israel is a small country located at the eastern end of the Mediterranean Sea. It was founded in 1948 as a homeland for Jews from all parts of the world. Israel is small, about the size of the state of New Jersey. Its current population is about 4.5 million people, 82% of whom are Jews and 18% are mostly Arabs. The Jews, many of whom emigrated to the country after its establishment, represent heterogeneous ethnic groups. The population is younger than those of Western European countries and the United States. Thirty percent are under 17 and 8.8% over 65. The majority of the population, about 90%, are city dwellers. Israel is a democratic republic with a parliament-cabinet form of government.

By most economic and social indicators, Israel may be considered a relatively developed or developing country. The literacy rate is about 95%. It has a relatively high standard of living, with a per capita income level categorized as high, and similar to those in such countries as Spain, Singapore and Ireland (per capita GNP for 1990 is $8615.). The country has a mixed economy, largely based on services and manufacturing industries.

Israel may also be characterized as a welfare state. It has quite an advanced system of social welfare insurance and services. The National Insurance Institute (NII) provides a broad range of benefits. These include old age and survivors' pensions, maternity benefits, family allowances, industrial injury benefits, unemployment compensation and disability benefits. The government also offers relief grants and an array of welfare and health services.

By most indicators used worldwide, Israel has well-developed health insurance and medical services. Ninety-six percent of the population is enrolled in one of several comprehensive health insurance plans, providing hospitalization and a wide range of other medical services. National expenditures on health constitute 7.4% of Israel's GNP. This proportion is higher than those for countries such as Denmark, England, and Japan. Health conditions in Israel are generally good. Life expectancy — 77.0 years for women and 73.6 years for men — is among the highest in the world, while infant mortality is among the

lowest. The ratio of physicians to population (1:340) and the number of specialists compare favorably with the most developed countries. The proportion of general hospital beds is 2.8 per 1000 of general population.

This introduction cannot be complete without mentioning two factors that shape the attitudes of the people in the country. Both are related to the very existence of Jews and the state of Israel. The common memory of the Holocaust, and the fact that since its establishment, Israel has been in a state of conflict with the Arab world, have a major effect on social and political life in Israel. The constant threat to the existence of the country and its people, intensified through several wars, has taken a toll on the social and emotional life of the people in Israel and created an enormous economic burden.

Brief History of Mental Health Services

Early developments. Although the formal history of mental health services in Israel can only start from the time the state was established, the beginning of mental health services goes back more than 50 additional years. The first institution designated specifically for mentally disordered persons was established in 1895. Two compassionate women founded the "Ezrat-Nashim" shelter in Jerusalem. Medical care, when available, was provided by general practitioners. It was not until 1921, that a trained psychiatrist practiced in the country (Dagan, 1988; Hailprin, 1937).

At the time of independence, there were 1200 psychiatric beds in Israel. Only 200 of these beds were provided by the government. There were two government mental hospitals, two public[2] mental hospitals and two inpatient psychiatric units in general hospitals. About two-thirds of the psychiatric beds were provided by private, for profit hospitals. The rate of psychiatric beds for the country was 1.32 beds per 1000 persons in the general population (Miller, 1977).

Mental health services were considered a low priority among the organized Jewish community prior to the establishment of the state. The General Sick Fund (Kupat Holim), the medical insurance and health care program of the major labor union (similar to HMO in the U.S.), which covered about 80%

of the population, resisted for a long time to include mental illness under its coverage (Brill, 1974). This fact, as well as the circumstances associated with the war of independence and the waves of immigrants that came into the country immediately after its establishment, explain the inadequate level of mental health services in the early years of Israel's history.

Mental health services were far from being able to respond adequately to the new circumstances which resulted from hundreds of thousands of immigrants that poured into the new country. It seems that a disproportionate number of mentally ill arrived in the country with many other immigrant groups (Aviram & Shnit, 1981). In addition, mental health needs among the survivors of the Holocaust were believed to be enormous. Attitudes regarding mentally ill persons, which in the prestate era were rather intolerant (Hailprin, 1937; Aviram & Shnit, 1981), changed. The general public, as well as the government, were sensitive to the needs of, and felt a moral commitment to provide services to, the concentration camp survivors (Ramon, 1981).

The major efforts of the mental health services of the new state during their first decade were to provide more psychiatric beds in response to the increased demand for inpatient care. The government used old army camps, an ancient Ottoman castle and jail, or deserted Arab villages, and also built new facilities in an effort to meet the demand for institutional beds. The General Sick Fund of the General Federation of Labor opened its second mental hospital in 1949. In one decade the number of beds increased by more than 2.5 times. In 1958 the number of psychiatric beds in Israel was 4335. The rate of beds was 2.2 per 1000 population, an increase of about 70% over the rate that existed when the state was founded. Until 1963 the increase in the number of psychiatric beds was proportionately higher than the general increase in the population (Chesler-Gampel, 1970). This achievement is indeed impressive, especially in view of the tremendous increase of the general population of the country during this period.

During the first half of the 1950s another process that shaped the mental health services for years to come was taking place. This was the legislation of the Mental Health Act, which in 1955

replaced the antiquated and inadequate Ottoman law that was in effect since the 19th century. Although at the time mental health services in Israel already represented different types of treatment and care, the Legislature chose to enact a law which related exclusively to inpatient hospitalization. The orientation of the law was based on the medical model, providing physicians with broad discretionary power regarding mental hospitalization and commitment (Aviram & Shnit, 1981; Bazak, 1972, 1979; Shnit, 1982).

Consolidation of the structure of mental health services. During the 1960s, new mental health services were added, and the system was consolidated. The major increase in ambulatory mental health services occurred during the second half of the 1960s and the beginning of the 1970s. Between 1965 and 1977 the number of outpatient service units increased by 70%, from 37 to 63 units. The increase during the following decade was only 10% (Popper & Rahav, 1984).

The structure of mental health services as it exists today was already in place in the early sixties. Mental health services included special psychiatric hospitals, inpatient psychiatric units in general hospitals, outpatient clinics, child guidance clinics, day hospitals, transitional facilities, institutions for long term care, and some rehabilitation services.

During the 1970s several community mental health centers were established, a few drug rehabilitation services were opened, and mental health hotlines began operating (Miller, 1977; Aviram & Shnit, 1981). The additions of the 1980s were primarily in the after care services — social clubs (Moss & Davidson, 1980; Naftally, 1986), sheltered homes (Hammerman, 1984), and rehabilitation services (Moss & Davidson, 1984; Levy & Davidson, 1988).

Inpatient services have mainly been provided by governmental hospitals or by private (for profit) hospitals, paid for by the government. The General Sick Fund's share in the provision of ambulatory mental health services was larger than its share in the provision of inpatient psychiatric services (Popper & Rahav, 1984; Kupat Holim, 1980, 1983). However, while the government was hardly involved in the provision of ambulatory general medical services in the country (those services were

provided mainly by the Sick Fund), a substantial proportion of ambulatory mental health services was provided directly by the government.

Reorganization plans and policy changes. During the 1970s two major policy changes were undertaken. In 1972 a plan for the reorganization of mental health services was announced by the government (Ministry of Finance, 1973). In its basic approach this "Reorganization Plan" was similar to the American model of the Community Mental Health Centers program. It called for the delivery of comprehensive mental health services in a geographically defined community (Tramer, 1972; Falik, 1978).

In 1977 the Government reached an agreement with the General Sick Fund regarding the provision of psychiatric services in the country. The guiding principle of this agreement, which became effective in 1978, was that psychiatric services should be provided on a regional basis, according to medical needs, and be free of charge. The Sick Fund was required to provide psychiatric services in the regions under its responsibility to all applicants, regardless of their insurance coverage, and in return, the Government assumed the costs of providing mental health services to members of the Sick Fund, as well as to anyone else, free of charge. It was an ambitious plan that attempted, among other things, to promote the Reorganization Plan and improve the delivery of mental health services in the country (Aviram & Shnit, 1981).

Following this agreement, the General Sick Fund amended its insurance coverage policy and eliminated coverage for psychiatric services for its member as of 1978 (Kupat Holim, 1986). Although there were no immediate practical consequences, this policy change represented a major retrenchment of the Sick Fund from its previously accepted responsibility toward the insured population, and created problems that surfaced later. Recently, in 1989, the Government changed its policy of providing psychiatric services free of charge, and has been attempting to collect fees for psychiatric services.

Until recently the Mental Health Services central administration was a separate branch of the Ministry of Health. Its independent status was never established by law and was rather an administrative arrangement. At the end of 1989, the Ministry

of Health announced its intention to change this organizational structure, and incorporate Mental Health Services, including its inpatient and outpatient services, into the Hospitalization Service Branch of the Ministry. At the time of the writing of this paper, the process of this administrative change has not been completed.

II. Israel Mental Health Service System

Changing Trends in Mental Health Services. The major efforts of mental health services during the first 15 years of the new state, until about the midsixties, were to increase the number of psychiatric beds and to organize the psychiatric inpatient services. This is not to say that professionals and policy makers were unaware of other needs, or that they completely neglected the development of other forms of mental health services.

During the 1960s, as immigration into the country decreased and economic conditions improved, attention shifted to ambulatory services. The number of outpatient clinics almost doubled, and the number of visits in them quadrupled between the years 1965 and 1977 (Rahav & Popper, 1984). Day care programs[3], not available until the late sixties, became available. The number of day care unit beds tripled during the seventies, and in 1985 exceeded 1000 (Central Bureau of Statistics, 1978; 1989).

After-care services, rehabilitation, and community care programs for long term mentally ill patients have been recognized needs, as well as being among the declared goals of mental health services for quite some time (Tramer, 1972; Miller, 1977). However, not until the 1980s could one observe some action in this arena. During this period social clubs and rehabilitation services were developed, and increased attention was given to the establishment of sheltered housing for mentally ill persons in the community.

There has been a noticeable decline in inpatient hospitalizations during the last decade. Epidemiological data reveal that this trend is reflected in all the usual indicators of inpatient services — the number of beds, resident population, and admissions. The trend is manifested in both absolute numbers and rates per populations (Popper & Horowitz, 1989; 1990). The number of patients in mental institutions in Israel continued to

Table 1

Inpatients and Day Patients in Psychiatric Care Facilities in Israel: Numbers and Rates of Resident Patients and Admissions in Selected Years: 1948–1988[1]

	1948	1958	1970[2]	1978	1988
	absolute numbers				
End of year					
Inpatients	1197	4188	8038	8925	7036
Day Patients	—	—	303	896	1220
During the year					
Admissions for Inpatient Care					
Total	n/a	4619	10577	12995	11035
First Admissions[3]	2593	n/a	4853	2933	
Readmissions[4]	n/a	2026	n/a	8139	8102
	rates per 1000 population				
End of year					
Inpatients	1.3	2.1	2.7	2.4	1.6
Day Patients	—	—	0.1	0.3	0.2
During the year					
Admissions					
Total	n/a	2.3	3.6	3.5	2.5
First Admissions	n/a	1.3	n/a	1.3	0.7
Readmissions	n/a	1.0	n/a	2.2	1.8

[1] Source: (Data is based on the Psychiatric Case Register reports.) Central Bureau of Statistics (1989) for 1958, 1970, 1988; Chesler-Gampel (1970) for 1948; Popper & Horowitz (1989) for 1978.

[2]From 1970 numbers do not include mentally retarded.

[3]Some figures are based on estimates.

[4]Some figures are based on estimates.

climb and peaked in 1978, with close to 9000 resident patients. By the end of 1988, the number dropped roughly 20% (7000). There is a similar trend of decline in the number of psychiatric beds. The trend of decline was a modest one at the beginning of the period, accelerating to an average of 4% decline per year

during the later part of the period. The decline in the rates of patients per 1000 of the population is even more impressive. The highest rate of inpatients per population was measured in the second half of the sixties. After 1970, the rate, which was about 2.7 per 1000 of the population, started to decline. The trend of decline accelerated during the last decade reaching about 30%, to 1.6 per 1000 in 1988 (Popper & Horowitz, 1989; Central Bureau of Statistics, 1989). The decline in the number of resident patients in institutions was for the short stay and the long stay patients as well. Between 1975 and 1988, the number of patients who were hospitalized one year or less declined by 19%. The rate of decline for this period for the longer stay patient was only 5.6%. During this period the proportion of the long stay patients in Israel mental institutions increased from 63% to 66.5% (Popper and Horowitz, 1990).

The number of admissions fluctuated during the second half of the 1970s and early 1980s averaging about 13,000 per year. It started to decline after 1981, dropping by about 15% between 1981 and 1988. The rates of admissions declined by 36% between 1973 to 1988, from 3.9 to 2.5 per 1000 of the population. An even higher rate of decline has been reported in regard to first admissions (Popper & Horowitz, 1989). Between 1975 and 1988, first admissions to mental hospitals declined by 50%, from 1.4 per 1000 of the population in 1975 to 0.7 in 1988.

The decline in inpatient hospitalizations is indeed impressive. Although the rate of decline is not so high as in the U.S., it is similar to the rates in other countries (Goldman, 1983), such as Britain, where deinstitutionalization trends were present during the last 25 years (Brown, 1985). In assessing this trend, Popper and Horowitz (1989; 1990), pointed out the increase in the number of day care unit patients, and the development of alternative care facilities in the community during about the same period. They attributed the changes to a configuration of factors — demographic, social, and clinical as well.

Institutional Care

Facilities. Psychiatric institutional treatmesnt and care are mainly provided by two types of facilities: special psychiatric hospitals and psychiatric inpatient units in general hospitals.

There is considerable variability within these facilities by the type of care, patient characteristics, costs, staff, ownership, and level of care. At the end of 1987, there were 38 psychiatric inpatient facilities in the country (Table 2). Almost half of the beds were in government special psychiatric hospitals. The second largest provider were private (for profit) psychiatric facilities. About 40% of the beds were in these hospitals (Table 3). Since the government pays for most of the patients in private hospitals as well as regulates these hospitals (Halevi, 1984; Ministry of Finance, 1989), one could say that about 90% of the psychiatric beds in the country are government beds.

Table 2

Psychiatric Inpatient Facilities by Type and Ownership. 1975, 1980, 1987[1]

	1975	1980	1987
Special Psychiatric Hospitals			
Government[2]	12	15	12
Private (for profit)	22	21	12
General Sick Fund	3	3	3
Other Not-for-Profit	3	3	2
Psychiatric Units in General Hospitals			
Government	3	4	5
General Sick Fund	1	1	3
Other Not-for-Profit	1	1	1
Total	45	50	38

[1]Source: Popper & Horowitz (1989); Mental Health Services (1989).

[2]Includes a forensic unit in a prison.

In 1980, there were 50 psychiatric inpatient facilities in the country. During an eight year period this number declined by one fourth (Table 2). The major decline occurred in the number of private hospitals. The total number of beds in private psychiatric hospitals diminished during this period by about 25%. This figure accounts for about 75% of the total decline in the number of psychiatric beds in the country. At the end of 1988,

there were 7362 psychiatric inpatient beds in Israel. (Table 3; Central Bureau of Statistics, 1989).

Table 3

Number and Proportion of Psychiatric Beds in Israel by Type and Ownership, Selected Years 1975–1987[1]

	1975	1977	1983	1987
Special Psychiatric Facility				
Government				
#	3593	3796	3881	3513
%[2]	44.1	42.9	46.5	47.2
Private				
#	3644	4094	3571	3080
%	44.7	46.3	42.8	41.4
General Sick Fund				
#	498	516	481	451
%	6.1	5.8	5.8	6.1
Other Not-for-Profit				
#	250	248	192	143
%	3.0	2.6	2.3	1.9
In General Hospitals				
Psychiatric Units[3]				
#	168	210	221	257
%	2.1	2.4	2.6	3.4
Total				
#	8153	8846	8346	7444
%	100.0	100.0	100.0	100.0

[1]Source: Popper & Horowitz (1988)

[2]Percentages are for columns

[3]Includes units in governmental, General Sick Fund and other public, not-for-profit hospitals.

The public (other than government) sector provides about 8% of the beds in special psychiatric facilities (Table 3). These beds are provided by not-for-profit organizations, of which the largest is the General Sick Fund. Considering that this health

Table 4

Admissions to Psychiatric Facilities in Israel by Type, 1988[1]

Type of Facility	Admission[2]	Beds[3]	Number of Admissions Per Bed
Government Special Psychiatric Hospitals			
#	6566	3513	1.87
%	55.9	47.2	
Private Special Psychiatric Hospitals			
#	470	3080	0.15
%	4.0	41.4	
Sick Fund Special Psychiatric Hospitals			
#	2507	451	5.56
%	21.3	6.1	
Other Nonprofit Special Psychiatric Hospitals			
#	235	143	1.64
%	2.0	1.9	
Psychiatric Units in General Hospitals			
#	1978	257	7.70
%	16.8	3.4	
Total			
#	11,756	7,444	1.58
%	100	100	

[1]Source: Mental Health Services (1989); Popper & Horowitz (1989)

[2]Includes admissions to day care in psychiatric hospitals (about 1/2% of total admissions).

[3]Figures for end of 1987.

organization covers about 70% of the population and provides 31% of general hospital beds in the country, the number and the

7% proportion of psychiatric beds provided by the Sick Fund, is relatively small (Ministry of Finance, 1989). Also, the proportion (3.4%) of psychiatric beds provided by general hospitals is rather small (Tables 2; 3).

Acute and long term care facilities. Psychiatric units in general hospitals and the Sick Fund hospitals provide mostly acute psychiatric inpatient services. About 40% of the admissions to inpatient psychiatric services in Israel during 1988 occurred in these facilities, which comprise only about 10% of the psychiatric beds in the country. Although also government hospitals were a major provider of acute psychiatric care, the large proportion of long stay patients in these hospitals (Popper and Horowitz, 1990), resulted in a lower rate of the number of admissions per bed in comparison with the general hospitals and the Sick Fund facilities (Table 4). Only 4% of inpatient care occurs in general hospitals. This proportion is lower than in other countries (Siegel et al., 1990).

Private psychiatric hospitals mainly provide long term care. Although 41% of the psychiatric beds in the country are in these hospitals, their proportionate share of the total yearly psychiatric admissions in the country was only 4% in 1988. A recent Ministry of Health Policy decision discouraged new admission to private hospitals. Ninety percent of the patients in these hospitals are hospitalized for periods longer than a year (Popper and Horowitz, 1990). These institutions are similar to nursing homes. They provide shelter and maintenance, with relatively little medical, social, or rehabilitative services. Staffing ratio per patient and cost of care are much lower than in other hospitals. The government sets up the fee schedules (which varies according to the type of population cared for), and regulates these institutions (Halevi, 1984). The quality of care in some of these institutions caused public concern, from time to time, and has been considered by some a disgrace (Neumann, 1982).

Admissions and resident patients. As already mentioned, there were about 11,000 admissions in psychiatric facilities in Israel during 1988. The rate of admission per 1000 population was 2.5. The number of resident patients at the end of 1988 was 7035 and the rate was 1.6 per 1000 population (Table 1). The majority of the admissions (73.4%) were readmissions. About 55% of all

admissions are males. Admissions by age and gender shows interesting differences. About 70% of male admissions are for the age groups of 18–44. The proportion of first admissions of these age groups among women is about 50%. Children (up to 17 years old) constitute 8.4% of first admissions. About one fourth of all admissions are between the ages of 18–24 (Popper and Horowitz, 1989; Mental Health Services, 1989).

Mental commitments. The majority of the admissions to Israel hospitals are voluntary. According to 1988 data, about 13% were admitted as civil commitments, and 4.5% were committed under the criminal code (Popper, 1989). Civil commitment is defined by the Israeli law within the realm of medicine, authorizing specially appointed district psychiatrists to issue commitment orders. Based on earlier data, the proportion of involuntary hospitalization may be higher, at about 24% of all admissions (Aviram & Shnit, 1984), which is more compatible with other countries (National Institute of Mental Health, 1987).

Diagnostic categories and chronicity. Schizophrenia is the major diagnostic category of persons admitted to institutions in Israel; 55% were so classified. Affective disorders are the second largest category, constituting 14% of all admissions. The proportion of this category among women is twice as high as for males (19.2% and 9.5% respectively) (Mental Health Services, 1989). Only 2.6 of the patients did not have any of the psychotic diagnoses (Siegel, 1990).

There is no accurate information regarding the proportion of chronically mentally ill persons in the country. Data on the length of stay of patients in mental hospitals reveal that 68.7% were hospitalized by the end of 1988 for more than a year. Almost 50% of all patients were hospitalized for 5 years or longer. The largest proportion of long stay patients was in the private hospitals (89.4%). The proportion of this category of patients in the government and the Sick Fund hospitals was lower (60.4% and 16.2% respectively) (Popper & Horowitz, 1990). These figures reflect the function of these hospitals and policies of their governing boards.

Length of hospitalization. Total numbers of hospitalization days for mental illnesses for 1988 was 537.8 per 1000 of the general population. Psychiatric hospitalization constituted 27%

of all hospitalization days in the country. Excluding hospitalization days for chronic illnesses and rehabilitation, hospitalization in psychiatric facilities was 40% of total hospitalization days.

The ;average duration of stay for those released during 1988 from psychiatric inpatient facilities was 224 days (compared to 5.1 days for those discharged from general hospitals) (Central Bureau of Statistics, 1989). The increase in the average length of stay for those discharged from mental hospitals in recent years, compared with 15 and 20 years ago, coupled with the declining numbers of residents and admissions in mental hospitals, indicate that recently a relatively larger number of long term patients have been discharged from mental hospitals than in previous years.

The average length of stay of 184.2 days for all patients in mental hospitals in 1987 was about the same as in the past (Ministry of Health, 1986). The average bed occupancy rates have been declining during the 1980s. This may indicate an improvement of hospitalization conditions. While during the 1960s and 1970s the occupancy rates were about 100%, for 1988 it dropped to 86.1%, becoming similar to the bed occupancy rate of medical beds (Central Bureau of Statistics, 1989).

Treatment modalities. The knowledge which is available and the high quality of training of mental health professionals provide mental institutions with access to high standards of treatment methodologies. Institutions use a variety of approaches to treatment and care. Specific information on the exact types of treatment methodologies and their differential use among institutions is not available, nor is there information on the distribution of professionals employed in the institutions by type of training and level of education. However, a review of the minimum requirements for those who wish to be hired, as well as the teaching material used for educating the professionals (e.g. Elizur, Tyano, Munetz, & Neumann, 1987) allow the conclusion that the level of training is high by any western standards, and that mental health services use a variety of mental health treatment modes such as psychodynamic, biological, psychosocial and so on. Although Israeli mental health professionals were initially heavily influenced by the Central European psychiatric tradition of the 1930s, and the psychodynamic tradition is still

quite influential, other approaches seem to expanding. There is a need for more specific and accurate information on this subject matter. Additional information regarding mental health personnel is discussed in the section related to staff.

Mental Health Services in the Community

The decline in the number and the rates of mental hospitalizations in Israel during the last decade has been attributed by some to the development of mental health services in the community (Popper & Rahav, 1984; Popper & Horowitz, 1989, 1990). Indeed the addition of outpatient clinics, day care units, community mental health centers, and some after care and rehabilitation services has changed the nature of mental health services in Israel. However, there is a need for studies assessing the direct influence of the community mental health services on the reduction of the resident population in inpatient care, and the exact contribution of the development of mental health services in the community to mental health services in general.

Based on a 1986 survey of psychiatric care utilization (Siegel et al., 1990), 68% of the care delivered in the week of the survey was in community facilities. During this week, 14,952 patient care contacts occurred in mental health facilities in the community. Since the survey was restricted to mental health facilities and since many patients receive care from other social and rehabilitation services such as the National Insurance local social service departments, as well as from private mental health practitioners, one may conclude that the number of care contacts of mental patients is substantially larger.

The bulk of the nonresidential community services were provided by outpatient clinics, which represented 80.8% of the patient care contacts during the week of the survey. Day care units provided 9.6% and social clubs 4.5%. The proportion of consultation was 5.2% of patient care contacts. About one half of the patients receiving care in community facilities had psychotic diagnoses, major affective or organic diagnoses, or were recipients of disability insurance. The others were rated as less dependent (Siegel it al., 1990).

Day care units. There were 1200 patients receiving care in 28 day care units at the end of 1988. These units were budgeted

Table 5

Outpatient and other Community Mental Health Facilities by Type and Affiliation, 1989[1]

	Gov-ernment	Sick Fund	Public (other)	Total
Day Care Units				
Total	18	8	2	28
At inpatient psychiatric facility	15	5	1	21
In the community	3	3	1	7
Ambulatory Units				
Total	39[2]	19[3]	4	62
At inpatient psychiatric facility	14	10	1	25
In the community	22[4]	7	3	32
Followup outpatient unit (at psychiatric facility)	3	2	—	5
Occupational Rehabilitation Units				
Total	7			7
At inpatient psychiatric facility	3	-	-	3
In the community	4	-	-	4
Drug Treatment & Consultation				
Total	6	1	10	17
Outpatient	4	1	10[5]	15
Day treatment	2	-		2
Consultation[6]				
Total		1	2	3
Social Clubs				
Total			33	33
Hotline				
Total			8	8
Consultation for Students				
Total			5	5

Sheltered Residential Programs in Community[7]				
Total	8	-	4	12
				182

[1]Source: Ministry of Health, Mental Health Services, Information and Evaluation Department. (1989). *List of Psychiatric Services in Israel.* Jerusalem: Ministry of Health.

[2]in addition, 6 clinics branches

[3]In addition, 2 clinics branches

[4]Most units are administratively connected to psychiatric inpatient facilities.

[5]Consultation services "Al- Sam"

[6]Not including psychiatric consultation services in general hospitals.

[7]Total for 1989, 177 residences; 285 residents. Sources: Report of the Committee on Sheltered Residence for Mentally Ill (1989); & Hammerman (1984).

by number of approved beds. The total number of beds were 938 (Table 5; Central Bureau of Statistics, 1989). Seventy five percent of the day care units were either in, or administered by inpatient facilities. About two thirds of the units were run by the government. Day care services were developed in the late sixties and early seventies. In 1970 there were 300 patients in these services in the country. The number peaked by 1987 and surpassed 1300, and later slightly declined.

Day care is mainly provided by the government and the Sick Fund facilities. The proportion of day patients per inpatients was higher in the Sick Fund facilities than in the government ones (454 and 290 per 1000 population, respectively, for 1987). The 1986 survey revealed that 80% of the day patients were adults, 11% were aged, 6% adolescents and 3% children (Ministry of Finance, 1989).

Since the classification of day care unit beds is not clear and the reporting system on day care patients has not been accurate, it is hard to judge how much of the increase in the reported day care is a reflection of a more reliable reporting system, and how much of it reflects a real growth. No doubt

that much more attention is currently given to this mode of treatment by practitioners and policy makers alike. There has been an impressive change in the proportion of day care patients compared with the total number of inpatients, from 10% in 1980 to 15% in 1988. However, this change is mainly a result of the decline in the number of inpatients during this period. Furthermore, the increase in the number of day care unit beds since 1980 consists only 10% of the number of inpatient beds which were closed since that time. Nor was there a significant change in the number of day care units in the country during the last decade (Ministry of Finance, 1987). Also, the rates of day care beds per population have remained about the same. While the rate of inpatient beds declined by about 27% between the years 1980 and 1988 (from 2.2 to 1.6 per 1000 population), the day care unit bed rate of 0.2 per 1000 of the population remained constant throughout the whole period (Central Bureau of Statistics, 1989).

Outpatient mental health services. Outpatient mental health services are provided by about 60 facilities. Approximately one half of these facilities are located in the community while the rest are in, or attached to, inpatient facilities. The number of the Sick Fund facilities are about 30% of the total number of outpatient mental health facilities in the country (Table 5). Until recently, outpatient services were provided free of charge. A new policy instituted a small fee for service. Decisions regarding the treatment and its duration are within the discretion of each clinic (Mental Health Services, 1984).

Information regarding the number and characteristics of patients receiving outpatient mental health services is less comprehensive than those about inpatients. According to the 1986 survey, there were 13,779 persons receiving ambulatory care in the community during the week of the survey (Ministry of Finance, 1989). Based on 1982 figures, it was estimated that there were about 36,200 new admissions to all outpatient psychiatric services in the country (Popper & Rahav, 1984). The number of contacts in outpatient services increased from 144,000 contacts during 1965 to 555,300 contacts during 1977 (Mental Health Services, 1984), and was estimated to reach about 700,000 in 1986 (Mental Health Services, 1990).

Community mental health centers (CMHC) were one of the central components of the 1972 Reorganization Plan of the Israeli Mental Health Services (Tramer, 1975). The first CMHCs, intended to serve as models for the rest of the country, were established in Ashkelon and Jaffa. Although other mental health outpatient clinics bear the title of CMHC or provide some of the services envisioned by the Plan, the concepts of CMHC program are far from being implemented in full. The 1978 agreement between the government Mental Health Services and the Sick Fund was reached in order to assure the delivery of comprehensive mental health services on a regional basis throughout the country. However, so far, no systematic assessment of the changes and their effect has been done.

Data on personnel in outpatient facilities is limited. Data from the 1986 mental health survey reveal that the total number of the equivalent of full time positions employed in public mental health services in the community was 714 (Mental Health Services, 1986). Since this number included also those employed in day care units and rehabilitation units administered by community mental health agencies, we can estimate that the number of positions in outpatient units was about 650. Research on personnel utilization in these type of mental health services has not yet been initiated in any substantial form and the information is only sketchy. Data on the Sick Fund mental health outpatient services, serving about 45% of the country's population, shows that at the beginning of 1985 the total number of positions was 233. Thirty two percent were psychiatrists, 21% psychologists, 16% social workers, 7% occupational therapists, 4% nurses, and 20% administration and maintenance (Kupat Holim, 1985).

A recent study of mental health outpatient services in Jerusalem illuminates some of the questions regarding characteristics of outpatients and types of services provided for them. About 40% of all patients who had attended the adult outpatient clinics in Jerusalem during a five week period in 1986 were in regular contact with the clinics for at least one year. Two thirds of those (or 27% of all patients) were diagnosed with one of the major psychiatric disorders, and either had previous mental hospitalization or received disability insurance or both. More than 90% of those diagnosed with major psychiatric disorders

received psyhotropic medication. The mode of treatment for the majority of these patients were non-psychodynamic. About 75% of them received treatment such as drug follow-up, supportive treatment, social clubs etc. (Lerner, Wittman, Zilber, & Barasch in press).

Emergency mental health services. Emergency mental health services on a 24-hour-a-day, 7-day-a-week basis are mainly provided by inpatient mental health facilities and by emergency rooms of general hospitals. Recently, the Sick Fund psychiatric hospitals and some of the government hospitals have developed special admission units with emergency holding facilities that provide intensive care on a short term basis. In addition, an emotional first aid hotline service is provided by a public organization (Eran) in eight locations in the country. Some outpatient community mental health services provide emergency services, however these are limited to regular working hours. There is rather limited information on these type of services.

Most of the general hospitals in the country have psychiatric consultation services. These services are available also in emergencies. Indeed, many of the mental health emergencies are first seen in the emergency rooms of general hospitals. A study of psychiatric referrals to a general hospital emergency room suggested that a combination of poor understanding of the general practitioner or the family doctor of when to refer urgently, efforts by these physicians to bypass clinic waiting lists, and lack of alternative community facilities might have accounted for the finding (Vigiser, Apter, Aviram, & Maoz, 1984).

Rehabilitation services. Increased interest of policy makers and some program administrators in mental health rehabilitation during the last decade resulted in several new policies and programs. However, in spite of some interesting and successful individual programs in this area, the scope of this service and the budgetary allocations for mental health rehabilitation services fall short of the needs. Rehabilitation has yet to assume its appropriate place on the mental health services priority list of policy makers in Israel (Levy & Davidson, 1988). Prior to the last decade the few rehabilitation programs were more or less a result of individual interest (e.g. Spivak, 1977) and not an outcome of a concerted policy effort.

Policies and programs in the area of psychiatric rehabilitation are within the domain of three governmental agencies: (a) Rehabilitation Services of the Ministry of Social Welfare, (b) national Insurance Institute, and (c) Mental Health Services of Ministry of Health.

Former mental patients are considered within the target population of the Rehabilitation Services of the Ministry of Social Welfare. The number of ex-mental patients among the clients of the rehabilitation centers administered by the Ministry of Welfare throughout the country is rather small. Two factors may account for this situation: Scarce resources and concerns about the potential negative effect of mentally ill clients on the programs and their public image.

As a result of the General Disability Law of 1974, the National Insurance Institute (NII) assumed a central role in rehabilitation programs for the mentally ill. This agency administers disability benefits programs, including income maintenance payments and rehabilitation services. The NII did not develop special rehabilitation services for the psychiatrically disabled persons and focuses on the occupational aspect of rehabilitation. The Ministry of Defense provides similar rehabilitation services to disabled veterans.

Mental Health Services views psychiatric rehabilitation as part of its domain. The interest and activities of the National Health Services in this area have increased during the last 10–15 years. Policy makers at the Mental Health Services believe that the special problems of mentally ill persons require that the Mental Health Services have the central role in the development and administration of rehabilitation services for mentally ill people whether they are located in the hospital or the community. An indication of the increased interest of Mental Health Services in rehabilitation services is the fact that since 1978, 10% of the disability benefits that the mental hospital receives for its patients from the NII is allocated for rehabilitation services.

Psychiatric rehabilitation services focus on the development of skills in three areas needed for successful community living — employment, social life, and housing. In the following sections, each of the services in these areas will be more specifically discussed.

Occupational rehabilitation. Occupational rehabilitation services have been considered relatively better developed than the other types of rehabilitation services (Levy & Davidson, 1988). There are two types of psychiatric rehabilitation services: (a) Transitional rehabilitation and training agencies, and (b) Sheltered workshops. While the first type emphasizes the education and training aspect of rehabilitation and integrates their programs with treatment services, the second type focuses on the provision of stable and sheltered work place for disabled mentally ill people.

In 1989 there were seven transitional rehabilitation services in Israel, providing services to about 300 persons. Four of these were provided in the community, while three were part of hospitals (Table 5; Popper & Horowitz, 1989). In addition, several sheltered workshops have been developed during the last several years as a result of special efforts of the government Mental Health Services, in cooperation with the NII and the Ministry of Social Welfare. There are seven such workshops in the country with a total number of about 200 clients.

Psychological rehabilitation. Although psychosocial aspects of rehabilitation are included in some of the transitional occupational rehabilitation services, the emphasis in those services is on the world of work. Psychosocial rehabilitation services geared to the training and education of former mental patient in and for community living are rather limited in their development in Israel (Spivak, 1977; Moss & Davidson, 1984).

Many new social clubs for mentally ill persons which have developed during the last decade function as psychosocial rehabilitation in addition to their purpose of providing leisure time activities for mentally ill people in the community. The development of these clubs is a result of efforts undertaken by "Enosh", a voluntary organization established by families of mentally ill persons in the late 1970s. In general, the established mental health service agencies have been supporting these efforts. Currently there are 33 such clubs in the country (Table 5; Naftally, 1986). The 1986 mental health survey revealed that 667 community service contacts during one week occurred in social clubs. This number represented 4.5% of patients in treatment by non-residential mental health services (Siegel et al., 1990).

Sheltered residences. Although early efforts in the development of sheltered care residences in the community started in Israel about thirty years ago, major efforts in this area have occurred during the late 1970s and 1980s (Hammerman, 1984: Levy & Davidson, 1988). A recent report indicated that there are 177 sheltered apartments for mentally ill persons located in the community. During the six year period, from 1983 to 1989, the number of residents in these facilities more than doubled. In 1989, 285 residents lived in these facilities. In addition there were about fifty residents in 3 hostels operated by mental hospitals and located in the community (Report of the Committee on Sheltered. . ., 1989).

Sources of financial support for these facilities varies a great deal. Some are budgeted in total by mental hospitals, others are supported by public voluntary organizations, while still others are paid for in full or in part by the residents. Disabled and dependent people are entitled to up to 95% of their rents (up to a certain level). Rental payments are provided to eligible individuals by the Ministry of Housing. In view of this fact, it is rather surprising that the number of mentally ill persons in sheltered facilities is not larger. Residents in some of the facilities which have been operated by hospitals continue to receive other services from the hospitals. Hospitals receive 50% of the Disability NII benefits for those residents living in sheltered residences under the direct supervision of the hospital.

Mental Health Service Expenditures, Budgets and Personnel

Expenditures for mental health services. Mental health services were allocated 12.7% of the total budget of the Ministry of Health for 1989. This amount was the equivalent of about 90 million dollars. There are no comparative figures for the budgets for mental health services provided by other sectors. Based on the fact that government expenditures for hospitalization in government hospitals and private hospitals are about 80% of all national expenditures on mental hospitalizations, a rough estimate for total expenditures for mental hospitalization would put the yearly figure between 100 to 115 million dollars.

Mental health services are the second largest item of direct costs (not conditional on income from outside resources) in

the budget of the Ministry of Health. The government directly operates 60% of mental hospitalization in the country and has been financially responsible for about 80% of these services. This proportion is quite different from the government proportion of the operation and financing of all medical expenditures. In the 1987/88 budget year, the government was responsible for the operation of 21.5% of total health service expenditures. It was financially responsible for 50% of these expenditures (Central Bureau of Statistics, 1989).

Distribution of budget between inpatient and outpatient services. Inpatient services take 90.4% of the budget. Calculating only direct services, excluding central administration and central services, inpatient services take up an even larger portion of the budget (93.5%). Community services are allocated about 5.3% of the total budget. More than 25% of these services are provided and administered by hospitals. Hospitals may provide additional community services, though these do not appear as a separate item in their budgets.

The high proportion of 90% or more allocated to inpatient mental health services is in sharp contrast to the distribution between inpatient and ambulatory care in the general medical services budget and expenditures. Expenditures for ambulatory medical services and preventive medicine is proportionally about the same as those for general hospital care (about 32% each) (Central Bureau of Statistics, 1989). The uneven distribution of the mental health budget has always been the case (Halevi, 1984; Aviram, 1983).

Staff. In May 1986 6247 full-time equivalent positions were employed in all mental health services in Israel. About 10% were physicians, 29% nurses 8.3% psychologists, 5.4% social workers, 5.3% occupational therapists, and 42% nonprofessional, including orderlies, nursing aides, maintenance personnel and administrative personnel (Mental Health Services, 1990). About 50% (3160 in 1988) of the mental health personnel were employed directly by the Ministry of Health. Only about 9% of all the people employed by Mental Health Services of the Ministry of Health were in community mental health facilities.

Training professionals for community mental health services have encountered difficulties (Aviram, 1977). It seems that pro-

fessionals prefer the more traditional inpatient and outpatient mental health services and consider them as a relatively desirable place for employment (Aviram & Katan, 1988). The prestige, however of psychiatry among physicians in Israel is rather low. Neumann (1982) asserted that a very small percentage (much smaller than in the United States) of graduates of medical schools in Israel chose psychiatry as their specialty, and that most of the psychiatrists in Israel are immigrants from Europe or the Americas.

Several changes have taken place in the number and the distribution of mental health personnel during the last decade. Data on mental health manpower in governmental services reveal that since 1979 the number of physicians increased by about 50%, the number of nurses and other professional personnel increased by 10%, while the number of maintenance and administrative staff remained the same (Ministry of Finance, 1979; 1989). If the numbers of professionals employed in mental health services, and their ratio to non-professionals is an indication of the quality of the services, then we must conclude that there has been an improvement in the mental health care services during the last ten years. In view of the fact that during the same period the numbers of resident patients in the government mental hospitals declined by 7%, the changes in the number and the distribution of the professional and non-professional staff is even more impressive.

However, the major part of the increase in the number of personnel occurred in inpatient services (Table 6). If indeed money would have followed the patients to the community, the 21% decline in the numbers of resident patients in all mental hospitals between the years 1978 and 1988 should have resulted in drastic changes in budgetary and personnel allocations for community mental health services. Instead of the present 5% or 6% budgetary allocation for, and 9% personnel positions in community services, the figure would be close to 25% and expenditures for community services more than four times higher the current level.

Table 6

Changes in Inpatients, Budgetary Allocations, and Manpower in Israel Mental Health Services, 1979–1988/89[1]

	1979	1988/89	Change
Inpatients			
Resident patients			
Numbers	8,774	7,036	(−) 20%
Rates[2]	2.3	1.6	(−) 30%
Admissions			
Numbers	12,958	11,035	(−) 15%
Rates[3]	3.4	2.5	(−) 26%
Budgetary allocations			
Percentage of Mental Health services of total Ministry of Health budget	13.6	12.7	(−) 8%
Percentage of community mental health of Mental Health Services budget[4]	5.0	5.3	(+) 6%
Percentage of "conditional expenditures" of mental health budget[5]	1.0	28.0	
Manpower			
Ministry of Health — Total	19,176	19,823	(+) 647 (+) 3.4%
Mental Health Services — Total	3,040	3,160	(+) 120 (+) 3.9%
Psychiatric hospitals	2,763	2,853	(+) 93 3.4%
Community mental health	277.5	285.5	(+) 1 (+) 0.4%
Percentage of mental health services of total Ministry of Health Manpower	15.9	15.9	N.C.
Percentage of community mental health of total mental health services manpower	9.1	8.9	(−) 2.2%

[1] Sources:
a. Inpatients (1979; 1988): Popper Horowitz (1989); Mental Health Services (1989).
b. Budgets and manpower (1979; 1989): Ministry of Finance (1979; 1989)

[2]Rates per 1000 of the general population

[3]Rates per 1000 of the general population

[4]Including also drug abuse treatment and community mental health services administered by hospitals

[5]Expenditures are conditioned on income from outside sources such as Disability Benefits or patients' payments.

Disability insurance and income maintenance programs. The Disability Law, implemented in 1974, had a paramount effect on services for the mentally ill and continued to affect the system for years to come. Discussing this law and its effect is beyond the scope of this paper. Briefly, the major effect of law on the mental health service system is three fold: (a) It provided income maintenance benefits to disabled mentally ill persons. (b) It established rehabilitation services within the National Insurance Institute, financed them with a portion of insurers' contributions, and offered rehabilitation services to mentally ill people who meet eligibility criteria. (c) It established, and continuously financed the Fund for the Development of Services for the Disabled, which has become one of the major funding sources for innovative programs in mental health rehabilitation.

III. Current Issues and Continuing Problems

Recent epidemiological data suggest that deinstitutionalization has been taking place in Israel. After a long period of stagnation, trends of mental hospitalization indicate, by all acceptable measures, that the change is real and substantial. Although this development could be attributed to a configuration of social, economic, and clinical trends, one should not minimize the contribution of the concerted policy efforts undertaken since 1972 to reduce mental hospitalizations and to increase and improve community services.

The Israeli mental health service system faces three interrelated problems: (a) Limited development of community mental

health services. (b) Dominance of the mental hospital in the provision and administration of mental health services in the country. (c) Medicalization of mental health services. These problems reflect, on the one hand, current organizational and financial issues, and on the other deeply embedded cultural factors and traditional belief systems.

Limited Development of Community Mental Health Services

Israel mental health policy, announced in 1972, and enhanced by a 1978 agreement between the Government and the General Sick Fund, called for drastic changes in the service delivery system. Based on the objectives of this policy and the experience gained in other countries, one would expect changes in the three most critical elements of the mental health system: patients, manpower, and financial resources. If indeed this policy had been implemented as stated, there would have been an observable change in the flow of these critical resources.

The significant decline in the number and rates of inpatient hospitalizations has not been accompanied by an equivalent increase in the resources provided for community services. Although, as has been noted, there were some positive changes in the provision of mental health service in the community, data indicate that those developments lag far behind what might be considered as justified and necessary.

Although there have been major declines in the numbers and rates of resident patients and admissions in mental institutions during the last two decades, the allocation of funds and personnel for, and within mental health services, has not been substantially changed (Tables 1, 6). The 1989 Ministry of Health budget for mental health services allocated 5.3% for community mental health services, while the proportion for inpatient services was over 90%. Even if one adds the allocations for community services through trust funds and foundations of which the government is a part, the total proportion of community mental health services of the budget would not change by more than 1%. This small proportionate allocation for community services has remained about the same during the 1970s and the 1980s (Halevi, 1984; Aviram, 1983).

The slow pace of development of community mental health services was previously pointed out (Israel State Comptroller, 1980; Aviram, 1983). Although there has been an increased attention toward, and some important additions to community mental health services, budget allocation for, and personnel deployment in community mental health services indicate that the general trend has remained about the same. Considering the changes in hospitalization trends and the knowledge about needs for community care and rehabilitation services, there is still much to be desired in terms of community mental health services in Israel.

Dominance of the Mental Hospital in Inpatient Services

The mental hospital has been occupying a central and dominant position in the mental health service system in Israel. Inpatient services consume and control over 90% of the budget. They pay salaries at higher levels than community services, and attract able personnel. The fact that many of the innovative community care projects have been initiated and administered by mental hospitals, is perhaps another indication of the central position of hospitals in the mental health services in Israel.

Due to the mental health law and regulations, as well as the structure of services, inpatient psychiatric services have a great deal of control over the flow of patients to and from mental hospitals (Aviram & Shnit, 1984; Aviram, 1983). Many of the community mental health services are provided by mental hospitals. Some are actually located on the grounds of mental hospitals. Others, even though located in the community, are administered by the hospital, and the mental hospital has control over their budget. For example, 75% of the day care units are located in inpatient facilities. In recent years many independent community mental health services were administratively attached, or put under the umbrella of mental hospitals. This trend is both a consequence and an indication of the supremacy of mental hospitals in the system.

This situation is not conducive to the development of community services, and is in contradiction to the knowledge regarding community care and rehabilitation programs for former mental patients. One must remember that the raison d'etre

of the hospital is inpatient services, and community services have lower priority. Furthermore, attachment of community programs to mental hospitals may enhance dependency inclinations in patients and slow community adjustments of clients. The stigma, unfortunately still attached to mental hospitalization, might also have a negative effect on the rehabilitation efforts.

Medicalization of Mental Health Services

Strong currents to further enhance the medical orientation of the mental health service system in Israel have recently been shaping the system. These trends have been influenced by ideological and theoretical convictions as well as by administrative considerations and professional-political interests. The recent decision of the Ministry of Health to change the organizational status of Mental Health Services from an independent branch to a section within the Ministry of Health Hospitalization Services (Milner, 1989) is a result of these trends and an indication of future directions.

Supporters of the administrative structural change have based their arguments on professional/theoretical reasons, as well as on administrative effectiveness and efficiency considerations. They claim that the medical model should guide the structure of mental health services and the treatment and services provided for mentally ill people. The argue that mental illness is a medical problem and within the domain of the medical profession. Recent research findings regarding the biological nature and etiology of the major mental illness — the argument continues — enhances these claims. Other professions, important as they are, are ancillary services. They emphasize that psychiatry is not different from any other medical specialty and does not need any special arrangements for the regulation of its practice or for the population and services within its domain. Following this logic, a special administrative branch for mental health services is not needed, nor is there a need for special laws regarding the mentally ill and mental health services.

From the administrative perspective, supporters of the changes believe that incorporating mental health services into Hospitalization Services, the dominant and strongest branch of

the Ministry of Health, would strengthen the internal organizational status of mental health services, and improve their chances to get a larger portion of the budgetary allocation.

Those who object to the changes contest some of the arguments and claim that, given the present needs of the mentally ill, level of knowledge, and type and array of services needed for them, the change in the administrative arrangements and the principles of the service delivery structure, are not justified or, at least, premature. Some believe that the changes have also been driven by professional — political and sectorial interests. Some professionals, being critical of the changes and the new administrative structure the mental health delivery system, have been arguing that these new trends represent a regression. They believe that these recent policy changes would hinder many positive developments that have happened, and would adversely affect the public mental health system in Israel.

Medicalization of the services for the mentally ill is not unique to Israel. Indeed, the recent changes in orientation have been similar to trends in other countries (Aviram, 1990). In Israel, where the deinstitutionalization movement has been a rather late arrival, and where the development of community care programs has been slow and far behind the needs, the effects of the intensive medicalization trends of the system might be quite negative. One of the problems resulting from the medicalization trends, is that the model of service is mainly acute and does not deal appropriately with chronic conditions. The medical model and the practice of curative medicine, the dominant approach used in other branches of the Israeli health services system, does not fit well with the needs and the service delivery system required for a large segment of the mentally ill population whose problems demand a life-long medical and social care system.

The expectation that mental health services would fair better within the administratively strong section of Inpatient Services than remaining a weak, independent branch in the Ministry of Health is questionable and could be proven unrealistic. In a situation in which the Government has continuously put pressure on the health care system to reduce its expenditures, mental health services is a rather weak competitor over the scarce

resources. The decline in the proportion of mental health services of the total budget of the Ministry of Health, and the tremendous increase in the proportion of budgeted expenditure conditioned on external sources of income in the budget of mental health services, are cases in point (Table 6; Halevi, 1984). Not having a separate and independent mental health service administration, around which a professional and public constituency may identify and can be organized, would politically weaken the service. Furthermore, it may increase the fragmentation of the mental health services in a time that persistent and coordinated efforts are necessary in order to respond adequately to the diverse and complex needs of the mentally ill.

Changes and improvements in social programs are usually not a result of a linear progression, but rather represent cycles with ups and downs. It seems that Israel mental health services is currently at a cross-road. Specific policy decisions may determine whether progress continues, or whether mental health services are entering a period of stagnation or even reversal of its previous positive achievements.

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Notes

1 Data for this section are based on the following sources: Israel Central Bureau of Statistics (1989), Israel Government Year Book (1989), Israel Ministry of Finance (1989), Encyclopedia Judaica (1972), Bank of America (1990), and Napzeger (1990).

2 In Israel the term public mental hospital denotes nongovernment, nonfor-profit mental hospital.

3 The term which is synonymously used in Israel is Day Care Unit (used henceforth).