



Myers-JDC-Brookdale Institute
Center for Research on Disabilities
and the Employment of Special Populations



Ministry of Health
Mental Health Services

EXECUTIVE SUMMARY

People with Severe Mental Disorders in Israel

An Integrated View of the Service Systems

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funding of the Laszlo N. Tauber Family Foundation**

The full version of this report is available in Hebrew, in print and
on the Institute website. Included with this summary are the
table of contents and list of tables and figures of the full Hebrew report.



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Executive Summary

The importance of community-based rehabilitation for people suffering from mental illness has earned growing recognition in recent years. There has also been growing recognition of the need to expand the database of those requiring rehabilitation and the services they receive. This follows the rapid increase in the number of recipients of disability benefits for psychiatric disorders from the National Insurance Institute (NII – Israel's Social Security Administration) and the fact that efforts to reintegrate people with severe mental disorders into society had been very limited. In consequence, the Community-Based Rehabilitation of the Mentally Disabled Act was passed in 2000, defining society's obligation to better include those with mental disorders by broadening the scope of community services and making them much more accessible. The existing information on the total number of people with severe mental disorders is very incomplete. Today, there are advanced information systems for each of the services. The various ministries, such as the Ministry of Health (MHS) and the NII, regularly publish statistics on the development of their programs. Nonetheless, there is no integrative information on the total number and percentage of recipients of rehabilitation services from the different systems. One of the main reasons is that there are several systems providing these services and each has its own separate database. In this study, we build on the existing information systems in each service in order to arrive at an integrated picture.

Against this background, the MHS and the Myers-JDC-Brookdale Institute launched an attempt to estimate the number of people with severe mental disorders who constitute the potential target group for rehabilitation; the scope of services offered by the different systems and the patterns of their provision. The study would not have been possible without the partnership of the Laszlo N. Tauber Family Foundation, established in 2003. One of the Foundation's main goals is to promote services, particularly rehabilitation, for people with psychiatric disabilities. To this end, it pursues a variety of strategies. It considered the expansion of knowledge on the subject and the creation of a combined database a highly important step to encourage national efforts in this area and to promote the work of all the different organizations involved.

One of study's main goals was to create a broad, integrated database to allow for an examination of the past and current situation so as to enhance existing rehabilitation services and future service planning. This, in order to better meet the needs of people with severe mental disorders and enable them to live as independently and inclusively as possible within the community.

The study was based on integrating the information at the individual/personal level from the administrative data files of NII, the Ministry of Health and the Ministry of Social Affairs and Social Services (MSASS). The project made it possible, for the first time in Israel, to create an integrated, multi-year database of people known to the relevant systems, their characteristics and the services they receive. This integrated perspective is rarely available also in other countries. The creation of the database was made possible by the willingness of all the organizations involved to make their case registries available for the shared goal of answering the study's key questions.

To ensure confidentiality, the data were encrypted in two stages in collaboration with the Central Bureau of Statistics (CBS). Researchers were thereby able to work with individual-level information that enabled cross-referencing the populations in the different files while preserving anonymity.

The report contains extensive information on those with severe mental disorders and consists of two parts: Part I reviews the various service systems for persons with severe mental disorders and is based on interviews and correspondence with key personnel in the different ministries and systems, on the data published by the various institutions and on previous research. It describes Israel's mental-health system, its relation to other systems and the place of the rehabilitation system. Mental-health care in Israel is delivered by a number of subsystems, managed mainly by the Ministry of Health. In addition, the health plans, NII, MSASS, and the ministries of Defense, Housing and Education provide services to persons with severe mental disorders. For each system, the report relates to the definition of people with mental disorders eligible for services and the type of services provided. It also briefly describes the official figures on the number of people served by each system. Note that since we did not have access to Ministry of Defense files, the population it identifies as suffering from mental disorders is not included in the integrated database we created, which is analyzed in Part II of the report. Nevertheless, Part I does describe the existing data on this population in some detail.

Part I also discusses the changes that have taken place in the mental-health and allied systems. The development of the mental-health rehabilitation system, including the enactment of the Community-Based Rehabilitation of the Mentally Disabled Act (2000), is described in the context of (1) the trend toward de-institutionalization and reducing the extent of psychiatric hospitalization and (2) the shifting of responsibility for rehabilitating people with severe psychiatric problems from MSASS to the Ministry of Health. Issues related to the future development of the rehabilitation system are also discussed, including the implications of the division of responsibility for rehabilitation, identifying unmet needs and addressing issues of stigma.

Based on the integrated database from the various systems, Part II attempts to estimate the size of the potential target groups for rehabilitation. The database contains information on recipients of NII disability benefits and of NII rehabilitation, on persons admitted to psychiatric wards or hospitals, on recipients of MHS rehabilitation, on persons treated for addiction, on persons treated at government mental-health clinics¹ and on persons receiving MSASS services in 2007 and identified there as suffering from mental problems. The unique linkage of data on the individual level made it possible to identify people with severe mental disorders who were known to one or more systems and thereby estimate their overall number. In addition, Part II relates to each system separately as follows: client characteristics over the years and characteristics of people *ever* known to each system and alive in 2007. We focused particularly on MHS and NII rehabilitation services, examined the patterns of receipt of services among potential target groups for rehabilitation, and considered differences in receipt of services by geographical district, age,

¹ The data of the Ministry of Health's mental-health clinics are updated to 2003.

gender, classification of a locality as Jewish/non-Jewish/mixed and its socioeconomic (SE) level (according to CBS definitions), severity (according to NII definitions) of psychiatric disability etc.

This summary presents selected findings from the full report. We will briefly describe Part I and then expand on the findings of Part II. It should be noted that the data of the two parts of the report may not be completely identical: Part I is based on the publications of the different systems; Part II – on the analysis of case registries supplied by the systems.² The inconsistencies may be due to, among other things, discrepancies in population definitions between system publications and our analyses.³

Main Findings of Part I – Service Systems for People with Severe Mental Disorders: Review of the Eligible Population, Services, Inter-System Relations and Key Issues in the Development of the Rehabilitation System

- ◆ As said, the services provided to people coping with psychiatric problems are spread over a number of ministries and organizations, each with its own eligibility criteria. Today, the connection between the mental-health and general-health system is very loose, and that between the various ministries providing services to persons with severe mental disorders, very limited. For certain cases there are inter-ministerial committees. The division of responsibility in service provision between different ministries and organizations may cause clients to "fall between the cracks", especially "borderliners" – e.g., people with personality disorders who do not fit any one system.
- ◆ In addition, the division of responsibility may cause a shortage of suitable services. Each system offers services for a disability or a problem under its responsibility and an individual with multiple disabilities may receive services suitable for only one of these.
- ◆ The Community-Based Rehabilitation of the Mentally Disabled Act was a very significant step in the development of rehabilitation services. Its importance clearly lies in establishing legal eligibility, defining the basket of services, and creating defined mechanisms to assess needs and provide services. Its importance is also reflected in a very significant expansion of the budgets available for supplying rehabilitation services. This development should be viewed against the background of recent efforts to reduce hospitalization and enable people to live adequately in the community.
- ◆ The law is being implemented gradually and does not purport to meet all existing needs. Unmet rehabilitation needs are reflected in the types of services provided and the fact that

² Most of the files were created in the course of 2008.

³ For example: Ministry of Health publications on hospitalization refer to the 15+ age group; our report refers to 18+. Similarly, some NII publications define their population by the client's main disability (for instance, mental disability) whereas our report defines the population by a psychiatric disability clause of at least 40% (hereafter: PCD40+). Furthermore, the systems update their data on previous years over time. The data presented in the report are valid up to the date of preparing the files (mostly, in the course of 2008). Finally, the files we analyzed do not include people deceased prior to 1990; therefore, the data for the years after 1990 are complete, whereas the data before 1990 are not.

certain populations ("eligible" and "ineligible" alike) do not receive appropriate responses to their needs. Thus, for example, the rehabilitation system is currently not equipped to deal with persons in the preliminary stages of illness even if, in principle, they are eligible for rehabilitation. Others are ineligible even though they would presumably benefit from rehabilitation, including those under 18 and those with a mental disability of less than 40% (PCD<40).

- ◆ Moreover, it is necessary to develop additional services that today are not included in the rehabilitation basket.
- ◆ Budgeting mental-health rehabilitation is complicated for several reasons. Firstly, because it is a fledgling system and various populations may not have adequate access to it, current utilization cannot serve as a basis for future budgeting. Moreover, there is no estimate of the total number of people requiring rehabilitation and consequently, of the budget necessary to address rehabilitation needs. Secondly, while the Community-Based Rehabilitation of the Mentally Disabled Act is defined in terms of personal eligibility, it has happened that the annual budget was exhausted and there were difficulties in obtaining supplementary funding. In addition, there is no automatic mechanism to adjust the budget to the population increase.
- ◆ Part I also discusses the problem of stigma and the barriers it poses to applying for service. Several possible interventions to help surmount this barrier are offered. The shortage of services, such as information and support for families, is also pointed out.

Main Findings of Part II – People with Severe Mental Disorders: Use of the Integrated Database from Various Service Systems to Examine their Overall Number, Characteristics, Relation to Rehabilitation Services and Changes over Time

1. Potential Target Groups for Rehabilitation Services

As noted, one of the study's main goals was to arrive at preliminary estimates of the size of the adult (18+) population with severe mental disorders, based on the populations known to the different service systems. The estimates include all those alive in 2007, *ever*⁴ known to the various systems,⁵ for whom, according to several indicators, the probability is high that they suffer from severe mental disorders. This population was identified as a potential target group for rehabilitation on the assumption that a significant percentage of those with severe mental disorders may benefit from rehabilitation.

Nonetheless, the suggested estimates of the potential population may be overestimates or underestimates. On the one hand, not everyone can necessarily benefit from rehabilitation; this can only be determined by professional assessment together with the individual involved and on a case-by-case basis. Some people function well enough, hence they do not need rehabilitation. On the other hand, there may be people who can benefit from rehabilitation but are not known to the systems examined in this study. One of the reasons that people in need of rehabilitation may not be in the systems today is that the available services do not address their needs.

⁴ "Ever" relates to the years for which there is information in each of the administrative files.

⁵ Including the Ministry of Health, NII and MSASS; excluding the health funds and Ministry of Defense.

1.1. Size of Potential Target Groups for Rehabilitation

The report presents 3 potential target groups for rehabilitation based on the probability that their members suffer from severe mental disorders and could therefore benefit from rehabilitation services. Each group incorporates its antecedent; the addition represents people for whom there is less certainty that they suffer from severe mental disorders (see Figure 1 below).

Out of the people *ever* known to the different systems and alive in 2007, we identified 120,000 for whom the probability was high that they suffer from severe mental disorders. For another group (40,000), the probability of their requiring rehabilitation is lower. It likely includes people with severe mental disorders, but we have no way of determining the proportion. Finally, for the remaining 80,000, we have no reason to assume that they require mental-health rehabilitation services. Note that the order of the target groups does not attest to the severity of the mental disorder, but to the degree of certainty, in our estimation, about the members of the group suffering from severe mental disorders.

Target Group A includes people eligible by law (today or in the past) for mental-health rehabilitation; i.e., people recognized by NII as having a mental-health disability of at least 40% according to Clause 33 or 34⁶ (hereafter PCD40+) or others who received MHS rehabilitation services. Not all current recipients of rehabilitation are awarded PCD40+ benefits: some rehabilitants do not meet the NII criteria for the extent of loss of earning ability or never applied for the benefit for various reasons, but are recognized on an alternative track as meeting the criteria of PCD40+. Others did receive the benefit in the past, but on reaching pension age, began to draw an old-age pension instead. At the same time, most MHS rehabilitants do receive PCD40+ benefits. For a small portion, those who received only a social club, it is not possible to assume with any certainty that they meet the PCD40+ criteria because, in the past, it was possible to receive a social club without having to pass through a rehabilitation committee (which examines, among other things, eligibility for PCD40+). Target Group A numbers **70,085** people of whom 63,537 are under pension age and 6,548 are over.

Target Group B incorporates Group A (70,085) and an additional **27,195** people with relatively severe diagnoses who do not receive PCD40+ benefits or MHS rehabilitation. Presumably, if these people applied to the relevant systems, it would be found that they meet the PCD40+ criteria. This group comprises **97,280** of whom 79,487 are under pension age and 17,793 are over. They were identified through diagnoses at mental-health clinics or during hospitalization.

Target Group C incorporates the previous 97,280 and an additional **23,294** who were hospitalized in psychiatric wards or hospitals more than once or once for a relatively long period, i.e., for more than the median duration of hospitalization in that period. Note that the length of hospitalization has shortened over the years. As a result, the same duration of hospitalization in recent years may attest to greater severity than the same period a decade ago. Consequently, we divided all those hospitalized only once into three groups: persons hospitalized in the past five

⁶ Clause 33 is defined as psychotic disorders; Clause 34 – as psycho-neurotic disorders.

years, persons hospitalized a decade ago, and persons hospitalized more than a decade ago. Target Group C numbers **120,574** people of whom 96,894 are under pension age and 23,680 are over.

A fourth group, D, identifiable in the administrative files are people not meeting the preceding criteria for whom there is nevertheless some basis to believe that they suffer from relatively severe mental problems although we have no indication of the severity. This group numbers 39,342 people and includes: NII rehabilitants with a mental disability of less than 40% (PCD<40); persons identified by MSASS as having a mental-health problem; recipients of treatment for addiction; persons who applied to the MHS rehabilitation system but received no rehabilitation; and persons who were hospitalized once for a relatively short duration.⁷ Presumably, this group contains persons who might benefit from rehabilitation but we are unable to estimate their percentage of the group total. This group numbers about 160,000. Of these, 131,000 are under pension age and 29,000 are over.

Thus, in total, the group that may be viewed as suffering from severe mental disorders is estimated at between 120,000 and 160,000. The 120,000 are viewed as those most likely to benefit from mental-health rehabilitation services, whereas of the additional 40,000, some may benefit from such services.

Finally, people treated at government mental-health clinics who do not meet the preceding criteria (about 80,000) fall into the last group and we do not relate to it as a target group for rehabilitation. The addition of this group brings us to the total of 244,000 identified in the database.

We examined differences by district in the percentage of people in the various target groups. To this end, we examined the percentage of people in a target group per/1,000 of the general population in that district. The percentage varies between districts, being relatively higher in the north and Tel Aviv districts and lower in the south for each of the 3 target groups. This is a reflection of differences in the number of people known to the various systems and not necessarily in the prevalence of illness per district. In other words, since the target groups are based on people known to the services – in districts where fewer people are known, the target groups are smaller even if actual morbidity rates may be higher.

⁷ One hospitalization episode shorter than the median duration of hospitalization in that period.

Figure 1: Potential Target Groups for Rehabilitation – Persons with Severe Mental Disorders Alive in 2007 and Known to the Systems

Target Group A: Legally Eligible for Rehabilitation (the vast majority)

Recipients of MHS Rehabilitation*
 Recipients of a PCD40+ NII disability benefit

Total: 70,085

Target Group B: Target Group A + Additional Persons Diagnosed with Severe Mental Disorders

Persons with schizophrenia, schizoaffective and delusional disorders excluding acute and transient psychotic disorders (categories F20-22, F24-29 on ICD10) and affective disorders depending on severity according to previous hospitalizations

Total: 97,280

Target Group C: Target Group B + Additional Persons with Relatively Multiple/Lengthy Hospitalization

Persons admitted to day hospitalization
 Persons hospitalized more than once
 Persons hospitalized only once but for a period longer than the median duration of hospitalization in those years**

Total: 120,574

A Fourth Group, D: Target Group C + Additional Recipients of Services of any Kind from at Least One System, Excluding MHS Clinics

Persons hospitalized once for less than the median duration in that period
 Recipients of NII Rehabilitation with PCD<40
 Recipients of Addiction Unit treatment
 Persons known to MSASS as suffering from a psychiatric problem

Total: 159,916

* Receipt of rehabilitation is defined as registration in the rehabilitation system for three cumulative months *ever* over the years (not necessarily consecutive).

** The duration of hospitalization has shortened over time. As a result, the duration of a specific episode of hospitalization may indicate greater severity than the same duration 10 years ago. We consequently divided all those hospitalized once only into three groups: those hospitalized in the past 5 years, 6-10 years ago or more than 10 years ago. We calculated the median duration of hospitalization for each of these groups.

1.2 Target Groups and Receipt of Rehabilitation Services

- ◆ Of Target Group A, i.e., persons eligible by law for rehabilitation, 34% *ever* received MHS rehabilitation (22% received vocational services; 20% – social club; 16% – housing services). In Target Group B, 24% received services and in Target Group C – 20%.
- ◆ The percentage receiving NII rehabilitation was 16% in Target Group A, 12% in Target Group B and 10% in Target Group C.
- ◆ The rate of recipients from at least one of the systems (MHS or NII) was 42% in Target Group A, 30% in Target Group B, and 25% in Target Group C. Thus, most of the people in the three groups never received rehabilitation services. As expected, the rate of non-recipients was smaller in Target Group A and rose consistently in Target Groups B and C.

2. MHS and NII Rehabilitation Systems

In this section, we elaborate on the changes over time in the number of recipients of rehabilitation from the various services.

2.1. MHS Rehabilitation

a. Population Size and Changes over Time

- ◆ In 2007, a total of 16,060 persons received MHS rehabilitation for at least one month, of whom 14,930 were under pension age.
- ◆ The number of people *ever* known to MHS rehabilitation services was 30,368. Of these, some 6,286 were registered but did not receive at least three months of services (not necessarily consecutively).
- ◆ The number of MHS recipients increased over the years. From 1997 to 2007, the numbers increased 2.7 times (from 5,800 to 16,000). Recipients generally remain in MHS rehabilitation for a long time.
- ◆ From 1998 to 2001, an average of some 1,500 newcomers entered rehabilitation annually. Since 2002, the figure has risen to some 2,000.
- ◆ People also leave the system, of course, whether due to death or to progress in their condition. Also, a certain portion apparently does not manage to integrate into rehabilitation services in their present form. An estimate of turnover was calculated according to the ratio between the number of rehabilitation recipients for at least one month during the year and the number of recipients in December of that year. The analysis demonstrates that the annual turnover rate decreased over time, from some 30% in 1997 to 15% in 2007.

b. Services Provided and Changes over Time

- ◆ In 2007, some 8,000 people received housing services; some 9,500 – vocational rehabilitation; close to 7,000 – social clubs, and 1,900 – mentoring services.
- ◆ Over time, there was an increase not only in the number of rehabilitants but also in the number of services received by those in the system. The change in the percentage of rehabilitants receiving each service varies.

- The number of housing recipients increased nearly 6 times. Some 25% of all rehabilitants received housing services in 1997 versus about 50% in 2007.
 - The number of vocational-service recipients increased 3 times though the percentage of rehabilitants receiving this service rose only slightly.
 - The number of social-club recipients nearly doubled though the percentage of rehabilitants receiving this service decreased.
 - The types of services offered within the various categories also grew differentially. Thus, for example, in vocational services, the increase in the number of recipients of sheltered workshops or supported employment (supervised integration into the free market as employee or self-employed) was greater than of vocational clubs (a pre-employment service for those not suited to sheltered workshops, teaching skills for future employment), which is aimed at people at a lower level of functioning. In other words, in the sphere of employment, the growth of services occurred especially in services for people at a higher level of functioning. In housing, the growth applied more to supportive housing than to hostels.
- ◆ Over the years, the percentage of MHS rehabilitation recipients among recipients of PCD40+ benefits almost doubled – from 12% in 1997 to 22% in 2007. This, despite the fact that the number of disability-benefit recipients grew significantly every year.

c. Population Characteristics and Changes over Time

- ◆ The percentage of recipients of PCD40+ benefits among MHS rehabilitants under pension age rose over the years from 71% in 1997 to 87% in 2007. This is probably a result of the Community-Based Rehabilitation of the Mentally Disabled Act, which makes receipt of rehabilitation services conditional on the PCD40+ category.
- ◆ In 2007, 17% of MHS rehabilitants had a 70%-100% psychiatric disability; 69% had 50%-69%; and 14% – 40%-49%. Over the years, there was a decline in the proportion of people with disability levels of 70%-100%, from 27% in 1997 to 17% in 2007.
- ◆ The percentage of rehabilitants with Clause 33 was significantly higher than that of those with Clause 34: 86% versus 14% respectively in 2007. This percentage dropped somewhat from 92% in 1997.. There was a similar decline among new entrants.
- ◆ Demographic Characteristics: The percentage of women among MHS rehabilitants increased from 39% in 1997 to 45% in 2007. In 2007, some 41% of the recipients were under age 40 and most (79%) were unmarried. The percentage of people over 50 rose from 21% in 1997 to 34% in 2007. Note that MHS rehabilitation services are generally long-term and the population of recipients is consequently expected to age. Among new recipients, there was an increase in the percentage of younger people aged 18-29.

d. Differences by District

To examine differences by district in the provision of rehabilitation services, we looked at the topic from three perspectives: firstly, among the total district populations, secondly, among the district recipients of disability benefits and thirdly among the potential target groups for

rehabilitation (Group C). The latter two perspectives relate differences in the extent of rehabilitation to indicators of the extent of need, as reflected by the size of the populations known to the systems.

- ◆ The rate of rehabilitation recipients per 1,000 residents in 2007 showed relatively small variation by district. It ranged from 5.4 in the Haifa district to 5.8 in the Jerusalem district, about 6.5 in the Tel Aviv district and 6.6 in the South district.
- ◆ However, when we allow for the variation in needs among districts, larger differences emerge.
- ◆ The rate of rehabilitants in Target Group C differed by district, ranging from about 15% in the Tel Aviv district to 19% in Haifa and the North and up to 25% in Jerusalem and the South.
- ◆ The rate of rehabilitants among recipients of PCD40+ who are eligible by the rehabilitation act differed by district, ranging from 15% in the North and Tel Aviv to 22% in Haifa and the Center and up to 27% in Jerusalem and the South.
- ◆ As may be seen, if we adjust for indicators of recognized need, the South still has the highest rehabilitation rate. However, Jerusalem is now also among the highest. At the same time, Tel Aviv and the North, which had the highest rates, are now among the lowest.
- ◆ The differences between the results of the three analyses stem from district differences in the rates of disability-benefit recipients and of members of Target Group C. These findings are consistent with the multi-variate analysis presented in the report (See Section 2.3).

e. System Overlap

To examine the extent of system overlap, we looked at people who had *ever* received MHS rehabilitation and had *ever* been known to other systems.

- ◆ Some 79% of recipients *ever* of MHS rehabilitation had been in psychiatric hospitalization; 77% had received a PCD40+ benefit; about half⁸ had been treated at MHS clinics; 27% were known to MSASS as having a psychiatric problem and 25% had received NII rehabilitation.

2.2 NII Rehabilitation

a. Population Size and Changes over Time

- ◆ The number of people with a psychiatric clause receiving NII rehabilitation increased in the past decade (1991-2007) by 2.3 times (from 2,100 to 4,800).
- ◆ The number of annual new entrants into the system was stable in the past decade, ranging from 1,400 to 1,600 people.

⁸ This is an underestimate, because the data from the clinics are only for 1997-2003; also, they cover only government clinics and not the public care provided by the health plans.

b. Services Provided and Changes over Time

- ◆ The main NII rehabilitation services offered in 2007 to people with a psychiatric clause were diagnosis (2,800), follow-up (1,650), and assistance with placement (about 1,000). In the past decade, there was a significant increase in the number of recipients of diagnostic and follow-up services. In the other services, there was only a slight rise in the number of recipients.

c. Population Characteristics and Changes over Time

- ◆ Of the total NII rehabilitants *ever* (17,877), about 60% met the criterion of PCD40+.
- ◆ In 2007, 34% of NII rehabilitants had a psychiatric clause of PCD<40. Most of the others (63%) had a psychiatric disability of 40%-70% and only 3% – of more than 70%. Over the years, the rate of people at relatively high levels of psychiatric disability (50%-100%) declined somewhat and the rate of those at lower levels rose.
- ◆ In 2007, 56% of rehabilitants with a psychiatric clause met the criteria of Clause 34 and 44%, of Clause 33. In the past decade, there was a rise in the rate of those with Clause 34, and a decline in the rate of those with Clause 33.
- ◆ In 2007, 44% of NII rehabilitants with a psychiatric clause were women, about 40% were under the age of 29 and 13%, over the age of 50. There has been no significant change in these characteristics in the past decade.

d. Differences by District over Time

- ◆ There were substantial district differences in the rate of people who *ever* received NII rehabilitation: the rate per 1,000 district residents ranged from 2.4 in the Jerusalem district to 4.4 in the North.
- ◆ Here, too, we examined the extent to which the differences stemmed from variation in the indicators of need by district.
- ◆ We found district differences for NII rehabilitants in Target Group C as well. The rate of recipients was lower in Jerusalem and the South (8%) and higher in Tel Aviv and the North (10%).
- ◆ NII differences by district thus showed an opposite trend to that of MHS rehabilitants.

e. System Overlap

- ◆ Some 49% of recipients *ever* of NII rehabilitation had been in psychiatric hospitalization; 60% had received PCD40+ NII benefits; 36% had been treated at MHS clinics (1997-2003); and 33% had received *also* MHS rehabilitation. About half of all NII rehabilitation recipients with PCD40+ received *also* MHS rehabilitation.

2.3. Relationship between Receipt of Services and Various Characteristics

We examined the relationship between receipt of rehabilitation services and selected characteristics. This was done in two ways: (1) Using a bi-variate analysis, for example, was there a higher rate of receipt among women than men? (2) We examined the contribution of the

various characteristics to the probability of receiving NII or MHS rehabilitation services, using multi-variate analyses. The summary of the analyses is presented in the table below. Unlike the bi-variate analysis, the multi-variate analysis estimates the contribution of *each* characteristic while controlling for the others. With regard to this analysis, note the following:

- a. The definition of receipt of rehabilitation used in the analysis of this section related to anyone who *ever* received rehabilitation. However, regarding MHS rehabilitation, there was a significant change in the number of rehabilitants in recent years so that the data tend to reflect the patterns of the past decade. In fact, 75% of MHS rehabilitants *ever* began to receive rehabilitation in the past 10 years. Regarding both services, we related to the years 1997 to 2007.

As noted above, the two rehabilitation systems provide different services: at NII, services focus on employment placement in the open market. MHS rehabilitation, on the other hand, provides a variety of services, including housing, personal mentoring, social and enrichment activities, and a broader range of vocational services.

- b. We examined two groups: The first comprised all recipients of PCD40+ NII benefits and numbered some 65,000 people. The second comprised everyone *ever* known to the different systems with a high probability of suffering from severe mental disorders (Target Group C), and the additional group (another 40,000 people) that may include people with severe mental disorders though we cannot estimate their number. In total, the group numbered some 160,000 people (Group D). Excluded were people known only to government mental-health clinics and not having severe diagnoses.
- c. We addressed four sets of variables: demographic (age, gender, marital status); residential (district, SE status of locality and whether the locality is Jewish/non-Jewish/mixed); severity of NII disability; and receipt of services from other systems.

The findings of the bi-variate and multi-variate analyses were very similar: that is, the relationships yielded by the bi-variate analysis were maintained even when controlling for other variables. Moreover, as may be seen from the table, the findings of the analysis were very similar for recipients of NII benefits and for those with severe mental disorders.

Probability of Receiving MHS Rehabilitation

Below, we summarize the main findings as to the probability of receiving MHS rehabilitation and then consider the differences regarding receipt of NII rehabilitation. The findings are similar for the two groups (NII disability-benefit recipients and Group D).

- ◆ Age lowers the chances of receiving rehabilitation. The chief difference relates to adults 50+.

- ◆ Residence in Jewish localities significantly raises the probability of receiving rehabilitation compared to residence in a non-Jewish locality. Possible reasons may be the population's awareness of rehabilitation options, a readiness to enter into the rehabilitation process, the availability of rehabilitation services in different areas, a service's cultural appropriateness or reluctance to apply due to concerns of stigma.
- ◆ Residence in a locality with a low socioeconomic (SE) cluster raises the probability of receiving rehabilitation.
- ◆ Residence in any of the districts versus the Tel Aviv district raises the probability of receiving rehabilitation, particularly in the Jerusalem and South districts. This trend is similar to that found in the bi-variate analysis.
- ◆ A higher level/percentage of disability and/or a classification of Clause 33 raises the probability of receiving rehabilitation.
- ◆ Receipt of services from additional systems (with the exception of the Addictions Unit) raises the probability of receiving rehabilitation. For example, people who had substantial hospitalization or people treated at government clinics for severe diagnoses or known to MSASS had much higher probability of receiving rehabilitation. This may reflect the severity of their condition or the fact that the other systems were referral agents for rehabilitation.
- ◆ Receipt of NII rehabilitation considerably raises the probability of receiving MHS rehabilitation. This may be because NII refers people to MHS for services that it does not supply and vice versa, or that there is simply a tendency to apply to both services.

In conclusion, the probability of receiving MHS rehabilitation is higher for younger people, for residents of Jewish localities, residents of localities with a low SE cluster, people with higher disability levels and/or people with Clause 33, residents of all but the Tel Aviv district, especially those in the Jerusalem and South districts, and for people known to additional systems.

Probability of Receiving NII Rehabilitation

With the exception of age and residence in a Jewish locality, most of the variables affect the probability of receiving NII rehabilitation differently. The probability of receiving NII rehabilitation is higher for those with lower disability levels, for residents of districts other than Jerusalem or the South, of localities with a high SE cluster and of Jewish localities. This may be because NII services focus on employment in the open market.

Summary of Multi-Variate Analysis of the Probability of *Ever* Receiving NII and MHS Rehabilitation among Recipients of PCD40+ Benefits and among the Overall Population of People with Severe Mental Disorders* (odds ratio)

	Among those with severe mental disorders		Among recipients of PCD40+ benefits	
	NII rehabilitation	MHS rehabilitation	NII rehabilitation	MHS rehabilitation
NII mental disability clause and disability percentage^x				
Clause 33 & 40-49% (vs. Clause 34 & 40-49%)				+
Clause 33 & 50-69% (vs. Clause 34 & 40-49%)			-	+
Clause 33 & 70-100% (vs. Clause 34 & 40-49%)			-	+
Clause 34 & 50-69% (vs. Clause 34 & 40-49%)			-	+
Clause 34 & 70-100% (vs. Clause 34 & 40-49%)			-	+
Gender: woman	+			+
Age 30-39 (vs. 18-29)				
Age 40-49 (vs. 18-29)	-		-	
Age 50 to retirement (vs. 18-29)	-		-	
Pension age and over (vs. 18-29)	-	-	-	-
Married vs. unmarried		-	-	-
District				
Jerusalem vs. Tel Aviv	-	+	-	+
North vs. Tel Aviv		+		+
Haifa vs. Tel Aviv		+		+
Center vs. Tel Aviv	-	+		+
South vs. Tel Aviv	-	+	-	+
Non-Jewish vs. Jewish locality	-	-	-	-
Mixed vs. Jewish locality	-		-	
Locality's socio-economic classification				
SE cluster (low)1-2 (vs. 7-10)	-	+	-	+
SE cluster 3-4 (vs. 7-10)	-	+	-	+
SE cluster 5-6 (vs. 7-10)	-		-	
Multiple/lengthy hospitalization vs. other or no hospitalization				
In clinics, with severe diagnoses	+	+	+	+
In Addiction Unit	-	-	-	-
MSASS recognition of mental problem		+		+
MHS/NII rehabilitant	+	+	+	+

* Everyone known to the different systems, excluding those known only to MHS clinics without severe diagnoses

^x Since there are no data on this population's clauses and percentages, these variables were not part of the analysis

+ = Significant positive correlation: odds ratio larger than 1.1

- = Significant negative correlation: odds ratio smaller than 0.9

Empty cell = no significant correlation: odds ratio from 0.9 to 1.1.

3. People Known to Other Systems

3.1 Recipients of PCD40+ NII Benefits

a. Population Size and Changes over Time

- ◆ Some 59,000 people received PCD40+ benefits in 2007.
- ◆ The number of people who *ever* received PCD40+ benefits and were alive in 2007 is 65,000, of whom some 60,000 are under pension age and 5,000 are over pension age. They constitute about 92% of Target Group A, 67% of Target Group B and 54% of Target Group C.
- ◆ The number of recipients of PCD40+ benefits almost doubled from 1997 to 2007. The rate of PCD40+ benefit recipients among the general population increased significantly since the start of the 1990s, from 0.7 to 1.4 in 2005. The rise was due to the increase in annual entrants and the fact that entrants remain in the system for longer periods (mostly until pension age when they move over to old-age pensions).
- ◆ Over the years and up to 2003, there was a gradual rise in the number of annual entrants with PCD40+ (from 2,000 to 3,000).

b. Population Characteristics and Changes over Time

- ◆ In 2007, 13% had a 70%-100% mental disability; 61% had a 50%-69% mental disability; and 26% had a 40%-49% mental disability.
- ◆ Over the years, there was a decrease in the proportion of recipients of benefits at the higher levels of mental disability (70%-100%), from 30%+ in 1980-87 to 13% in 2007. Correspondingly, there was a considerable increase in the proportion of recipients of benefits at the lower levels (40%-49%), rising from 2%-4% in 1980-87 to 26% in 2007. These trends are also apparent among entrants to the system.
- ◆ About two-thirds of benefit recipients in 2007 had a Clause of 33, and a third – of 34. Over the years, the proportion of all benefit recipients (PCD40+) with a Clause of 34 rose from 15% in 1980 to 33% in 2007. This is also a reflection of the decrease in the level of disability of new recipients.
- ◆ Demographic Characteristics – the proportion of women has been stable, and was 41% in 2007. The percentage above the age of 50 rose steadily over the years from some 13% in 1990 to 34% in 2007. Concurrently, the proportion of 18-29-year-olds decreased from 26% to 17%. The rise in age derives from those remaining in the system for life and less from an increase in the entrance of older clients. The proportion of new entrants to the system aged 18-29 was 43% in 2007.

c. Differences by District

- ◆ There are differences between the districts in the rate of people per 1000 who *ever* received PCD40+ benefits. The rate varies from 9 in Jerusalem to 11 in Haifa, 12 in the south, 13 in the center and reaches 17 in Tel Aviv and 18 in the north.

- ◆ There were differences by district in the proportion of people in Target Group C who *ever* received PCD40+ benefits. The rate of recipients was lowest in Jerusalem and Haifa (45%), followed by Tel Aviv (53%), the Center and South (54%), and highest in the north (67%).

d. System Overlap

- ◆ Of recipients *ever* of PCD40+, 28% received MHS rehabilitation, and 16% received NII rehabilitation. In total, 36% received from MHS or NII (8% received only from NII; 20% received only from MHS and 8% received from both. Some 60% had been hospitalized in Israel at some time. Some 35% were treated at government mental health clinics; 21% were known to MSASS in 2007 as suffering from a psychiatric problem and 34% were not known to either the MHS rehabilitation system or the psychiatric hospitalization system.

3.2. Full (Inpatient) Psychiatric Hospitalization and Day Hospitalization

- ◆ In 2007, some 15,000 were fully hospitalized in psychiatric wards. The number of people in full psychiatric hospitalization annually has not grown since the early 1990s.
- ◆ The number of people in psychiatric day hospitalization steadily increased in the 1990s to some 4,000, began to drop from the year 2000 and in 2007, was 2,500.
- ◆ Given that Israel's total population has grown, this means that the rate of adults hospitalized is decreasing, which conforms to the policy of cutting back on hospitalization. In 1997, the percentage of people in full hospitalization was 0.4% and in 2007 it decreased to 0.3%. This trend is stronger in terms of average hospitalization days.
- ◆ Among people alive in 2007, The number of people who had *ever* been in full psychiatric hospitalization was some 100,000; in day hospitalization – 29,000.
- ◆ The rate of women in psychiatric hospitalization has declined over the years. In 2007, it was much lower than their rate in the general population (38% vs. 51%). The rate of women in day hospitalization was also low – 41% in 2007.
- ◆ Over the years, there was some rise in the rate of young people (18-29) who were fully hospitalized and a considerable drop in the rate of people over pension age. This may partially reflect the discharge of people who had long lived in hospitals and moved to old-age homes or other facilities. The age distribution of people in psychiatric day hospitalization has not changed substantially over the years.
- ◆ System overlap: some 18% of those *ever* in psychiatric hospitalization received MHS rehabilitation; 9% received NII rehabilitation, 38% received PCD40+ benefits and 30% were treated at government mental-health clinics. Some 60% of all those *ever* in psychiatric hospitalization did not receive MHS rehabilitation or PCD40+ benefits.

3.3 Services provided by the Ministry of Health Addiction Units

- ◆ From 1996 to 2007, there was a significant increase in the number of people treated at the ministry's Addiction Units, from 1,000 to 3,500. In recent years (since 2004), the number of service recipients stabilized.

- ◆ In total, 8,000 people were treated from 1995 to 2007. The rate of young people (18-39) among service recipients decreased over the years from 76% in 1995 to 33% in 2007. Concomitantly, the rate of older adults (50+) rose from 3% to 23%.
- ◆ The percentage of women treated at the Addiction Units was particularly low, 12%-14%.
- ◆ About a fifth (21%) of the people treated by Addiction Units received PCD40+ benefits; about 16% were hospitalized in a psychiatric hospital or ward and at least 18% were treated at MHS clinics. Thus, there is less overlap between this population and that of the other systems.

3.4 Ministry of Social Affairs and Social Services (MSASS)

- ◆ In 2007, some 33,000 were known to MSASS as suffering from a psychiatric problem (suffering from a mental disorder and/or the reason for being in the case load was a psychiatric problem).
- ◆ A relatively very high percentage were between 40 and 65 – almost 50% of the population known to MSASS. Correspondingly, the percentage of young people (18-29) was especially low: 14%.
- ◆ The percentage of people known to MSASS and living in non-Jewish or mixed localities was similar to the percentage of residents in these localities in the general population, as was the distribution according to the locality's SE cluster.
- ◆ About half of the people known to MSASS in 1997 as suffering from a psychiatric problem had been known before 2000, i.e. they have been in the system for a long time.
- ◆ Of those known to MSASS in 2007, some 40% *ever* received PCD40+ benefits; some 40% were *ever* fully hospitalized; 24% were *ever* in MHS rehabilitation; 10% *ever* received NII rehabilitation and 30% were *ever* treated at MHS clinics.

3.5 Government Mental-Health Clinics (MHS)

- ◆ The number of people treated at MHS clinics rose from 1997 to 2003 by 50%, from 33,000 to 49,000.
- ◆ In total, some 120,000 were treated at government mental health clinics from 1997 to 2003.
- ◆ Non-Jewish localities were under-represented among MHS recipients.
- ◆ Some 20% of the people *ever* treated in MHS clinics received PCD40+ benefits. About a quarter were *ever* fully hospitalized and about 10% were in day hospitalization. Some 12% received MHS rehabilitation and 5%, NII rehabilitation.

Conclusion

The study demonstrates that it is possible to obtain very important insights into the size of the population with severe mental disorders and the extent of rehabilitation services by integrating the data from the different systems that address the needs of this population. For the first time in Israel, it has been possible to create an integrated, multi-year database of persons known to the different systems, their characteristics and the services they receive, by precisely and almost fully identifying the persons concerned, across the systems. Note that although the data are not based

on identifying people with severe mental disorders in the general population – it may be assumed that in a state with a highly developed medical system and social service, most of the severe cases were known to some service at some time.

The study shows that the size of the population with severe mental disorders is significantly larger than the number of people with severe mental disorders identified by each system separately. The estimated number is between 120,000 and 160,000. As reported by Ministry of Health publications, there has been a significant increase in the availability of rehabilitation services since the passage of the rehabilitation act in 2000. Still, the study findings indicate that most of those identified as suffering from severe mental disorders do not and did not in the past receive MHS or NII rehabilitation, and there are important differences in the proportion of recipients, by population group and district, which need to be addressed. As we saw, since 1997 there has been a significant decrease in the scope of hospitalization. There is evidence from Israel that this is in part attributable to the development of community rehabilitation services. Such links have been found in studies abroad.

The present report provides a basis for more comprehensive planning of the development of rehabilitation services and for strengthening the connection between the different systems serving this population.

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