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The rehabilitation of the mentally disabled in the community act in Israel: Entrepreneurship, leadership, and capitalizing on opportunities in policy making

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ABSTRACT

This paper examines the role of policy entrepreneurs in the formation of a rehabilitation program in the field of mental health in Israel, shedding light on their role in general and specifically in mental health policy formation.

Our research is based on a historical case study. The legislation process was examined through interviews with key actors in the legislative process and archival materials.

While in general our findings reinforced existing literature, our research also revealed new information on several topics: organizations as policy entrepreneurs; inter-sectorial coalitions of entrepreneurs; and possible problems arising from the concept of 'leadership by example'.

1. Introduction

Policy entrepreneurs are actors who work in an uncertain policy arena to effectively promote their policy agendas. Policy entrepreneurship has become a prominent component in explanations of policy change processes. While Kingdon (2014) popularized the concept more than three decades ago, the last decade saw a rising interest and much discussion of this term, beginning with Mintrom and Norman's (2009) extensive analysis. However, as they claim (p. 662), the concept requires further research to fully understand the mechanism of action and the impact of policy entrepreneurs.

This paper aims to further our understanding of policy entrepreneurship in two ways: first, we wish to employ the concept of policy entrepreneurship to mental health policy, a field which, to our knowledge, has not yet been sufficiently analyzed from this perspective; moreover, applying the concept to a new case study advances the research on policy entrepreneurship in general. We believe that our findings will support and strengthen current knowledge while expanding our understanding of several aspects in the theory of policy entrepreneurship.

Following, we will analyze the Rehabilitation of the Mentally Disabled in the Community Act, legislated in Israel in 2000, an act that led to a rehabilitation reform in the Israeli mental health services, and which, in our opinion, would not have occurred without the actions of several policy entrepreneurs.

1.1. Shaping policy: between external circumstances and policy entrepreneurs

According to Kingdon (2014), policy change is the result of **a policy window** – a consolidation of circumstances that enables the promotion of a new policy, which occurs when the three independent policy streams – the problem stream, the policy steam, and the politics stream – meet. The appearance of a policy window, though, is not enough. A policy window is a window of opportunity, and someone must seize this opportunity. These are **the policy entrepreneurs**, who are willing, according to Kingdon, "to invest their resources – time, energy, reputation, and sometimes money – in the hope of a future return. This return might come to them in the form of policies which they approve, satisfaction from participation, or even personal aggrandizement in the form of job security or career promotion." (pp. 122–123). In other words, policy entrepreneurs actively strive to promote the policy they prefer, enabling the opportunities opened by the policy windows to be realized and the shaping of the new policy.

Mintrom and Norman (2009) likewise emphasize the relationship between the circumstances and the actions of policy entrepreneurs. They claim that to understand policy entrepreneurship fully, one's attention must simultaneously be aimed in a multitude of directions: both contextual and structural factors; actions by individuals against the backdrop of these factors; and the way the context has shaped these actions.

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The circumstances in which policy entrepreneurs act are crucial. When the circumstances lead directly to changes, the actions of policy entrepreneurs are inconsequential, because the change will happen even without their intervention. When the circumstances greatly inhibit the possibility of change, the policy entrepreneurs will fail in their attempt to change it. Only when the odds counter the possibility of change, but there is still some probability of its occurrence, is it conceivable that the actions of policy entrepreneurs become significant.

For this action to indeed be significant, proper conditions are not enough. Policy entrepreneurs must act effectively. Mintrom and Norman (2009) list four main characteristics that policy entrepreneurs must possess to be successful: displaying social acuity, defining problems, building teams, and leading by example. **Displaying social acuity** is manifested by the ability to quickly and accurately identify social conditions; it is necessary, because, as mentioned above, policy entrepreneurs can be effective once a policy window is opened, but to exploit this situation, they first must recognize it. The ability to **define problems** has to do with the effect of the policy entrepreneurs on the definition of the problem they are dealing with, and the central role of this definition in shaping the chosen policy. The ability to **build teams** relates to the fact that policy entrepreneurs only rarely have the power to change policy by themselves. To influence policy, they are forced to create coalitions and cooperate with a variety of actors. Therefore, their ability to cooperate and build solid and effective work teams is crucial to achieving their goal. **Leading by example** enables policy entrepreneurs to promote the proposed policy on a small scale, to prove that it does not entail many risks.

While Mintron and Norman focus on the characteristics of policy entrepreneurs, Cohen (2012) sheds light on the interaction between policy entrepreneurs and the contexts in which they operate. He defines a policy entrepreneur as follows: “an individual who exploits an opportunity to influence political results for his/her own benefit, in the absence of the resources required for accomplishing this goal alone.” (p. 7). This definition includes the distinction made by Mintrom and Norman and quoted above, that policy entrepreneurs succeed in achieving their goals only when the chances of success are neither too great or too small. Only when the individual cannot effect change on their own but can do so by exploiting the power balance, can he or she become a policy entrepreneur.

Following, Cohen identifies three elements that affect the timing in which policy entrepreneurs appear (or in our own formulation, the timing in which certain actors begin to operate as policy entrepreneurs): (1) the entrepreneur's desire to maximize **personal gain** following action designed to impact policy; (2) a complete **absence of any option** to effect such change on their own; (3) **the appearance of an opportunity** to influence the shaping of policy.

In light of the above, this article focuses on an attempt to understand the transition of the mental healthcare system in Israel from quintessentially medical models to models that include rehabilitative aspects, focusing on the actions of policy entrepreneurs against a background of changing external circumstances.

2. Material and methods

This research examines the process of a policy change which led to the passage of the “**Rehabilitation of the Mentally Disabled in the Community Act**” in Israel (hereafter referred to as the Rehabilitation Act). The research period spans from November 19, 1997, the preliminary reading of the act, to July 11, 2000, the date the Knesset, the Israeli parliament, passed the ground-breaking act.

Most of the data for this research has been gathered through semi-structured interviews with people who took part in the process of shaping the act. The list of interviewees included officials who were active in the legislative process from the relevant government Ministries (Health, Finance, Social Services), the mental healthcare system, the Knesset and the NGO sector. The pool of interviewees was expanded employing the snowball method: the first people to be interviewed were selected based on the researchers' familiarity with prominent actors in the field, and each of these people was asked to refer the researchers to other subjects who may have relevant information.

In addition to these interviews, supplementary data was collected from two sources: the minutes of the Knesset assembly and its committees in debates regarding the act, and official documents and correspondence on this subject. These last were taken from the Knesset archives, which includes the correspondence of official figures in the Knesset, and from the archives of *Otzma – the National Forum of Families of Mental Patients*, which includes this organization's correspondence with other actors, as well as other data collected by the organization.

The collected data was analyzed using historical case study methodology, to identify the Act's stages of development, the various factors that impacted its development, and the balance of power between them.

3. Results

Throughout most of the 20th century, the preferred treatment for people with severe mental illness was hospitalization. In the early 1970s, activists and professionals began to question this tendency. The anti-psychiatric movement, and later the call for de-institutionalization, doubted the effectiveness and humanity of hospitalization, and concurrently the growth of consumer movements in mental health (Bassuk & Gerson, 1978; Mechanic, McAlpine, & Rochefort, 2014). Advanced psychiatric medications enabled a more effective treatment of severe mental illness (Goodwin, 1997; Grob, 1994; Mechanic et al., 2014; Shorter, 1997). These processes led to the development of approaches that focused on rehabilitation rather than hospitalization (Corrigan, Mueser, Bond, Drake, & Solomon, 2008).

While **medical models of mental illness** focus on treating the symptoms of the illness with medication and other therapeutic means, **rehabilitative models** seek to help such people by expanding their prospects of integrating into the community and furthering their ambitions and goals (Anthony, 1993; Carpenter, 2002). Rehabilitation is systemic use of various means of action designed to encourage people suffering from severe psychiatric illnesses to develop their capabilities fully, through study and surrounding support. People cannot achieve this goal when they are cut off from their environment and staying at a secluded facility. They need their natural environment, their families and the community in all its strata. Thus, the rehabilitative model is closely related to de-institutionalization (Corrigan et al., 2008).

Throughout the 1970s and’80s, this approach grew and took root in the professional community around the world, and also gained expression in the healthcare systems of a growing number of countries. (Guy, 2004; Goodwin, 1997; Knapp, McDaid, Mossialos, & Thornicroft, 2007; Slade, 2009; Thornicroft & Tansells, 2009).

By the end of the 1980s and the beginning of the 1990s, these approaches began to be implemented by the Israeli mental health professional community, and rehabilitative initiatives began to appear both in psychiatric hospitals and in the community. At the time of the legislation, unfortunately, these initiatives were sporadic, limited, and underfunded (Sharshevsky, 2015).

3.1. The active parties in the passage of the legislation

The legislation of the Rehabilitation Act commenced in June 1997, when MK Tamar Gozansky submitted a draft Bill to the Knesset (The Israeli Parliament). The Bill was passed in its preliminary reading despite government opposition.

Gozansky had a key role in forming the coalition that promoted the legislative process. Through intensive research in the field of mental health rehabilitation, she became familiar with the existing rehabilitation options, the various interested parties and the people working in

the field, and studied the needs de facto. Then she created a new coalition, which included the Rehabilitation Division in the Ministry of Health's Mental Health Services and the *Otzma* organization. This process enabled her to promote the Bill and enlist support for it while ensuring that it provided a solution for the needs of those dealing with mental health issues. Her stated final goal was to pass an Act that would serve as the basis for a mental health rehabilitation system. All those interviewed agreed that without Gozansky's thorough actions, this Act would never have become a reality.

MK Mrs. Gozansky did not act alone, as organizations representing former patients and families of the mentally ill worked with her. The main organization involved in promoting the Act was *Otzma*, which represented the families of mentally ill patients. This organization received professional and legal backing from *Bizchut*, The Israel Human Rights Center for People with Disabilities.

The different relevant organizations, with *Otzma* at the forefront, played several important roles in promoting the Bill. First and foremost, they promoted the field of rehabilitation and managed to prevent the topic's dismissal from the public agenda, emphasizing its importance. Also, they maintained a radical position regarding the interests of mentally disabled persons and their families. They represented their interests and fought for them at every debate. In so doing, they limited the ability of their allies – especially MK Gozansky and the representatives of the Rehabilitation Division – to prefer organizational or political considerations over those pertaining to the interests of the mentally ill persons. At the same time, they enabled these allies to present themselves as advocates of a moderate position – between that of the families and that of the Act's detractors – increasing the chances that the Act is passed.

Finally, the organizations enabled their target population to be heard and represented them in all the discussions about the Act. This role was particularly crucial when working with public representatives – Knesset members and government officials – and enabled them to emphasize the importance of the Act, making clear what was and what was not in the interest of the consumers.

The third partner in shaping the Bill was the Ministry of Health. Unlike the other two partners, the Ministry of Health is a complex organization, and different units within it represent different interests. Research participants and archival data unveil a constant tug-of-war that took place regarding the Ministry of Health's official position. On the one hand, The Rehabilitation Division within the Mental Health Division's wished to maximize the budgets allocated to it, and increase the number of patients eligible for rehabilitation. On the other hand, the directors of the governmental psychiatric hospitals sought to keep most of the patients and budgets under their care, thus viewing an extensive rehabilitation system as a potential threat. As a result, a struggle ensued over the support of the central administration of the Ministry of Health, including the leadership of the mental health services, through the Ministry's general director, and up to the Minister himself.

The main force promoting the Bill within the Ministry of Health was the Rehabilitation Division, and specifically its director, Yehiel Shershevski. According to interviews, Shershevski identified the Bill as an opportunity to overcome the lack of an organizational and legal framework for the activities of the Rehabilitation Division, an obstacle which grew larger as the psychiatric rehabilitation system expanded. Therefore, Shershevski became convinced that rehabilitation must be legislated into law, and together with MK Gozansky began to promote this cause. While, as shown below, their efforts outside the Ministry of Health were successful, the level of support inside the Ministry of Health was mixed and inconsistent.[1]

The psychiatric establishment, specifically the directors of the psychiatric hospitals, formed the main opposition to the codification of the rehabilitation system. While most representatives of the psychiatric system, including hospital directors, publicly expressed their support for the development of the rehabilitation system, they simultaneously acted behind the scenes, advocating a rehabilitative system inside or under the supervision of the hospitals, or even opposing the establishment of the new system altogether.

At first, it seemed that the scales were tilted decidedly in favor of the hospital administrators. The Rehabilitation Division was, at the time, quite new, with limited resources and organizational power. The hospital administrators, on the other hand, were perceived as the true power holders within the Mental Health Division (See for example Aviram & Azary-Viesel, 2018b).

Despite this imbalance of power, the Rehabilitation Division prevailed, and the Ministry's support for the legislative process was secured, albeit at varying levels of commitment, as described below. The triumph of the supposed underdog was the result of three main components: the political efficacy of the head of the Rehabilitation Division, Yechiel Shershevski, and of the former Director of the Ministry, Prof. Mordechai (Motke) Shani; external interests (mostly of the Ministry of Finance) beyond this issue, which impacted the balance of power; and finally, the partial compensation promised to the hospital directors for possible losses.

The Rehabilitation Division, led by Shershevski, employed two main means to change the balance of power. They effectively lobbied the upper management within the Ministry of Health, starting with the head of the Mental Health Division, through the Director-general of the Ministry, and up to the Minister himself. And they enlisted to their cause collaborators outside the Ministry of Health who shared their interests, chiefly the Ministry of Finance, whose involvement is described below, but also the families' organizations, MK Gozansky, and many others. These alliances, held for the most part behind the scenes and at times even against official regulations, served not only to recruit support for their position but also to coordinate positions and consolidate complimentary political strategies. This constituted a significant asset and promoted the Division's position both internally, within the Ministry, and externally.

A major factor in deciding the internal debate within the Ministry of Health was the legislation's projected impact on wider Ministry interests. Interviewees assert that the Ministry was highly interested in both the completion of the transfer of responsibility for mental healthcare to the HMOs[2] ("The insurance reform")[3] and compliance with the interests of the Ministry of Finance's Budget Division.

The legislation of the Rehabilitation Act came shortly after a failed attempt to transfer the responsibility for the mental health system from

[1] Dror and Maoz (2011) argue that the impact of the senior management at the Ministry of Health on the passage of the Rehabilitation Law was crucial, and was expressed in moves made "on the ground". It is true that Yechiel Sharshevski, who was in fact the head of the Rehabilitation Department at the Mental Health Services, but is not considered part of the Ministry of Health's senior management, did indeed greatly impact the shaping of the Law. However, the findings of our research dispute Dror and Maoz's claim. The senior management's support of the Rehabilitation was at best mixed and lukewarm. The legislation's greatest supporter at the top levels of the Ministry of Health was Prof. Shani, who at the time held no official position at the Ministry. The position of the heads of the Mental Health Division towards the law ranged from support to opposition throughout the legislation period, and enlisting this support was a major part of the struggle for the act, as we shall show in detail.

[2] The HMOs in Israel (Kupot Holim) are non-profit organizations, similar to the HMO in the US, and are the main suppliers of physical health services in Israel. They operate both as insurers, supplying health insurance to every Israeli citizen, and as suppliers of (mainly primary) health services.

[3] In Israel, the term 'Insurance Reform' in mental health in Israel refers to the transfer of the responsibility for mental health services from the Ministry of Health to the HMOs. The first attempt to carry out this reform took place in the years 1995–1998, shortly before the legislation of the process described in this paper. The reform materialized only in 2017.

the Ministry of Health to the HMOs, who were traditionally in charge of the physical health system, as part of the National Health Insurance Act (Aviram, Guy, & Sykes, 2007). One of the main reasons this attempt failed was the reluctance of the HMOs to accept the responsibility for long-term inpatient care in mental hospitals. The prevailing mindset at the Ministry of Health was that a developed rehabilitation system, which would reduce the number of psychiatric inpatients and lower the budgetary cost of the mental health sector, would facilitate the HMOs ability to "swallow the bitter pill" and enable them to accept the responsibility for the population's mental health. Because the Ministry of Health viewed the completion of this reform as in its interest, its leadership sought to promote the rehabilitation system (Aviram et al., 2007).

Another organizational unit that would benefit from the proposed rehabilitation system was the Ministry of Finance's Budgets Division. For reasons explained below, the Budgets Division viewed the establishment of a broad rehabilitation system as in its interest. Beyond the weight of this interest on the inter-Ministry level, it also deeply influenced the intra-Ministry level, within the Ministry of Health. As the Budgets Division is the most significant actor in government policy in general and in healthcare in particular (Asiskovich, 2011; Cohen, 2012), Interviewees testified that various officials within the Ministry of Health sought to prioritize the rehabilitation field. They believed that if the Ministry promoted plans viewed as advantageous by the Budgets Division, in return the Division would be favorably inclined to support proposals the heads of the Ministry of Health wished to advance.

In addition to these factors, several steps were taken to mitigate the opposition of hospital directors and minimize the harm they perceived they and the hospitals under their care would incur if the Act were passed. The main reduction in the number of inpatients would be in private (for profit) psychiatric hospitals, minimizing the impact on their public counterparts (Ministry of Health, 2009, 2013, 2016). In fact, despite the reduction in the number of patients, the hospitals' budgets were not cut (Aviram & Azary-Viesel, 2018a; Aviram & Azary-Viesel, 2018b), and the personal status of the hospital directors (and head nurses) was maintained, rather than reduced to correspond to the new, reduced, hospital size (M. Sneidmann, Personal communication, April 30, 2014).

Within the Mental Health Division at the Ministry of Health, the proponents of rehabilitation and those of hospitalization fought over the support of figures high up the Ministry's chain of command. The three managerial levels relevant to this issue were the Head of the Mental Health Division, the Minister of Health, and, to a lesser degree, the Director-General of the Ministry. The identity of the people who held these positions during the relevant periods had a crucial impact on the promotion of the Act.

The head of the Mental Health Division is directly in charge of the mental healthcare system (but not of the psychiatric hospitals, which report to the Director-general), and therefore his position had a decisive effect on the development of the rehabilitation system. Traditionally, the head of the Mental Health Division would seek, upon leaving the Ministry, an appointment as a hospital director, and consequently needed the recommendations of other directors. Therefore, he was organizationally connected to the hospital directors and tended to represent their interest. Also, it can be assumed that he had no incentive to harm a system he saw himself joining in the future.

However, during most of the period discussed in this article, the Mental Health Division was headed by Dr. Mordechai (Moti) Mark (first term until May 1996; second term from July 1999), who came from the IDF, the Israeli military, where he headed the Mental Health Department, a position he filled again in between his two terms at the Ministry of Health. Mark was committed unreservedly to the rehabilitation efforts. This commitment produced results: Mark founded the Rehabilitation Division in his first term in the position, and did much to expand it; in his second term, the legislation shifted into high gear, and the main shaping of the Act took place, ahead of the second and third calls.

Between the two terms of Dr. Mark, the position of head of the Mental Health Division was held by Dr. (now Prof.) Zeev Kaplan. Dr. Kaplan followed a more traditional route towards this position, accepting this job after heading the Beer Sheva Psychiatric Hospital and returning to that hospital not long after his term as head of the Mental Health Division had ended. Kaplan's positions towards the broader issue of rehabilitation and the legislation, in particular, was, according to interviewees, at least partially influenced by his previous place of employment and his next foreseeable one. He held a position similar to that of the psychiatric establishment – advancing from opposition to rehabilitation in the beginning, to limited support, focusing on rehabilitation within hospitals. Accordingly, during his tenure as division head, the legislation did not halt, but its progression slowed significantly.

The Ministry of Health is responsible for all the healthcare legislation in the country, and thus the Minister of Health has the power to decide whether the Ministry supports or opposes any legislation. It is therefore not surprising that much of the intra-ministerial struggle over the Rehabilitation Act was expressed by lobbying the Ministers of Health.

The ministers of health during the legislation period were Yehoshua Matza (up to July 6, 1999) and Shlomo Benizri. The interviewees described a spirited struggle for the support of the Ministers, which included a prolonged process of persuasion and a determined, consistent effort to develop connections with those close to them to gain a supportive voice in their circle. Access to key figures close to the Ministers, was, according to the interviewees, a key means of persuading them and bringing them to support the Act.

In the case of both Ministers, the interviewees described their support of the Act as the main factor that enabled its passage. Interestingly, they described this as happenstance, almost random result of the lobbyers' access to those close to the Minister and encounters with him under various circumstances. This is how one of the interviewees describes his interaction with Matza:

> *The way policy is determined… it's not always rational. Matza had an assistant; she was a social worker, I can't remember her name. She had an influence on him. So we got to her, we succeeded in convincing her to convince [Matza]. He actually made the call on the last moment. […] If we weren't getting to this social worker we weren't getting to Matza like this, so to this day, I'm afraid, [rehabilitation] was still within the hospitals. […] I must say, I consider this a happenstance and not something we worked on.*

Similar accounts were given regarding access to those close to Benizri. From their reports, we may, therefore, assume that under different circumstances, such as lesser access to the Minister or a strong opposing opinion, the legislative effort would not have become a reality.

The two Director-Generals of the Ministry of Health who served during the legislative process, Prof. Yehoshua Shemer and Prof. Gabi Barabash, had limited impact on the legislative process. They delegated responsibility on this matter to Prof. Mordechai Shani, whose work on the process was critical. Prof. Shani, a former director-general, held no official position in the Ministry at the time of the legislative process, but all the interviewees agreed that his influence at the Ministry was crucial, particularly regarding the rehabilitation reform.

Shani contributed much to the promotion of the Act. He headed the inter-Ministerial committee that designed the pilot program and was the first chairperson of the Rehabilitation in the Community of Persons with Mental Disabilities Council. He consistently supported the establishment of a broad, legally-backed rehabilitation system, and acted to the utmost of his abilities to promote it, in formal and informal channels alike. Shani's actions had a far-reaching effect, both on the support of the Ministry's upper echelon and on the support of people and organizations outside the Ministry of Health, particularly at the Ministry of

Finance.

After reviewing the history of the struggle regarding the Act within the Ministry of Health, we now turn to track the same developments in the other Ministry whose influence on the legislation was significant – the Ministry of Finance.[4] The Ministry of Finance and its Budgets Division, which was the Ministry's agent in the Rehabilitation Act's legislative process, have immense power in shaping policy in Israel, including the realm of healthcare policy. Some researchers even believe it has unofficial veto power (Asiskovich, 2011; Cohen, 2012). Therefore, the position of the Ministry of Finance had an overwhelming impact on the progression of the legislation.

The representatives of the Budgets Division enthusiastically supported the expansion of the psychiatric rehabilitation system. This support was obtained following great efforts by supporters of the rehabilitation system – at the Rehabilitation Department of the Ministry of Health, the Knesset, and the third sector – via formal and informal channels alike.

Interviewees from the Budgets Division listed three reasons for their support of the rehabilitation law: the effect of rehabilitation on patients' lives; its effect on their productivity and specifically labor force participation, which could lead them to cease receiving disability payments and start paying taxes; and fiscal savings due to the decreased number of inpatient beds following successful rehabilitation.[5] Although the Ministry of Finance's officers stressed that they supported the Act for all three of the reasons above, many of the interviewees believed that the main reason was fiscal savings and that the officers were only paying lip service to the two other factors.[6]

Although the Budgets Division supported the development of the rehabilitation system, it did not support its establishment via legislation. From the point of view of the Division's officers, the legislation would have compelled the state to allocate a rehabilitation services package to anyone who met the set criteria, whereas establishing a rehabilitation system without legislation would have enabled the Ministry representatives to budget the system while balancing budgetary capacity versus rehabilitation needs. In this manner, the budgetary allocation, and hence the definition of balance, would remain at their discretion, and they could have promoted the principles of outsourcing social services and social investment without simultaneously promoting the principles of universal, entitlement-based services. This is how MK Gojansky presents her interaction with the Ministry of Finance representatives in the Labor, Welfare, and Health committee of the Knesset:

> *In discussions I had with those responsible in the Budgets Division of the Ministry of Finance, they did support the idea of rehabilitation, and the argument, mister chairman, was beyond the humanitarian aspect of integrating the mentally disabled in the community. The argument was also financial. The argument is that better integration of the mentally disabled in the community will decrease hospitalization. Hospitalization is very expensive, and thus you can give a better quality of life and save the state a lot of hospitalization. […].*
>
> *The argument and discussions fared on several issues. One main issue was that the representatives of the ministry of finance continually opposed the legislation, claiming that they agree to allocate funds, but not that legislation will cement eligibility of the patient to this service, and this is an old argument with representatives of the Ministry of Finance. In every field, they are sometimes ready to give something, but not that the legislation will say that there's an entitlement. It's a fundamental disagreement.*

This position – of supporting the expansion of the rehabilitation system while opposing its codification in legislation – was unique to the Budgets Division, thus limiting the Division's ability to create alliances and promote it. The main interest of the Budgets Division was to expand the rehabilitation system, and therefore its allies were proponents of rehabilitation, especially officials from within the Ministry of Health. However, those supporting rehabilitation enthusiastically supported the legislative process as well. When the representatives of the Budgets Division attempted to promote the division's position of expanding rehabilitation without legislation, they were left without support. This may explain why the Ministry of Finance, which usually gets its way, failed this time, despite its great power. As the legislative process progressed, the members of the Budgets Division realized that their ability to promote their preferred solution was diminishing. They may have likewise understood that due to the widespread support for the Act, the chances of them stopping it were slim. Therefore, they chose to support it, and try as best they could to manipulate it in a manner which would serve their interests. Due to this newly-acquired support, the division managed to achieve a number of advantages, which mitigated its loss of budgetary control resulting from the legislation. The main achievement was an agreement signed between the Ministry of Finance and Prof. Mordechai Shani, on behalf of the Director-General of the Ministry of Health. This agreement made the Ministry of Finance's support for the bill and its subsequent funding contingent upon strict benchmarks, including the reduction of the number of beds at psychiatric hospitals and minimization of the average stay per patient at such hospitals. In other words, The Ministry of Finance effectively conditioned the allocation of funds to the rehabilitation system upon the same funds being conserved from the hospitalization system.

4. Discussion: the contributions of policy entrepreneurs to the shaping of the rehabilitation of the mentally disabled in the community act

From this description, we see that the conditions in the mental healthcare system in the late 1990s created a situation that corresponds with Mintrom and Norman's (2009) theory. Though the structural conditions that enabled the introduction of a rehabilitation reform did develop, these conditions did not lead directly to policy change, due to opposing structural factors. As Mintrom and Norman argue, such a situation is fertile ground for action by policy entrepreneurs.

As described above, the anti-psychiatric, the de-institutionalization, and the consumer movements on the one hand, and the second wave of psychiatric medication on the other led to the promotion of rehabilitative approaches worldwide. While these views began trickling into Israel, local actors were also active in promoting the policy window which enabled the passage of the Rehabilitation Act: the National Healthcare Act. The desire to transfer the responsibility for mental healthcare from the Ministry of Health to the HMOs was a substantial institutional factor, as was the support of the Ministry of Finance. This support was the most significant institutional factor that enabled the actions of the policy entrepreneurs and the passage of the Act, but at the same time was the result of the actions of the policy entrepreneurs.

Though powerful, these factors were insufficient to bring about the rehabilitation reform on their own, as evidenced by the failure to codify a rehabilitation system as part of the insurance reform of the National Healthcare Act in the mid-1990s. Back then, powerful actors, headed by the directors of psychiatric hospitals, did all in their power to block the move.

Such a situation, where the odds of advancing policy are similar to the odds of failing to do so, requires the action of policy entrepreneurs.

[4] Another government Ministry that was part of the legislative process was the Ministry of Welfare and Social Services. As the contribution of this Ministry to the final structure of the law was minor, and its involvement does not pertain to the topics discussed in this article, it will not be elaborated here.

[5] In retrospect, this argument was justified. In the first decade following its enactment, the Rehabilitation Law produced savings of approximately one billion ILS, which represents the cost had the rehabilitated patients remained in the hospitals (Aviram, 2012).

[6] See, for example, Minutes No. 20 of the Labor, Welfare, and Health Committee of the 15th Knesset, October 19, 1999.

As is made clear by the description above, many actors in the policy-making arena deserve recognition for their part in passing the Rehabilitation of the Mentally Disabled in the Community Act. Some of them were even "veto players"(Tsebelis, 2002), and if not for their contribution, the Act would never have come into being. However, an examination of the term "policy entrepreneur" reveals that it applies to only four people or groups who took part in passing the Act: MK Tamar Gozansky, the head of the Rehabilitation Division Yechiel Shershevski, the leaders of the *Otzma* organization, and Prof. Mordechai Shani.

According to Cohen's definition cited above (Cohen, 2012, p. 7), a policy entrepreneur is "an individual who exploits an opportunity in order to influence political results for his/her own benefit, in the absence of the resources required for accomplishing this goal alone." Each of the four parties identified above, and even all four together, lacked the resources needed to complete the passage of the legislation. They exploited the opportunity they identified to impact policy, in this case in a successful, indirect manner. Following, we shall compare the actions of these four against the characteristics of policy entrepreneurs as identified by Mintrom and Norman.

Social Acuity – The ability to quickly and accurately identify social situations. All four of these policy entrepreneurs displayed social acuity: Tamar Gozansky identified a problem that wasn't being treated but had the potential for change. Beyond this, Gozansky was able to formulate the Bill, to recruit the coalition that led the legislation (the *Otzma* organization and the Rehabilitation Division at the Ministry of Health), and also make use of the legal option to submit a private Bill, which was politically neutral, and recruit the support of many Knesset members, regardless of their political affiliations. The representatives of *Otzma*, through the *Bizchut* organization, were able to study the various legislative options promoted in the mid-90s, and identify the one that had the best chance of passing. This was in contrast to other NGOs, who focused on different legislative efforts, which failed. Yechiel Shershevski identified the right opportunity to advance the Bill, joined forces with MK Gozansky, and through collaboration with *Otzma* managed to bring the government to support the Bill. When the issue came before him, Prof. Mordechai Shani was able to recognize the opportunity that the rehabilitation reform offered the mental health-care system and the healthcare system in general, and the potential alliances that would enable the advancement of the issue.

Defining problems – Defining the problem was one of the fundamental issues addressed within the struggle to pass the Rehabilitation of the Mentally Disabled in the Community Act. A central part of the legislative process was the dispute over the definition of "rehabilitation" and "community." As argued above, as the legislative process progressed, the psychiatric hospital directors sought to define rehabilitation in a way that would leave a large part of the rehabilitation activities within the hospitals. The Act's proponents, headed by *Otzma*'s representatives, waged a determined struggle to have rehabilitation defined in a manner that would promote the establishment of rehabilitation opportunities in the community system, consistent with the principles of the rehabilitation approach.

Team-building – This feature was also a major factor in the struggle. All those interviewed for this research, especially the policy entrepreneurs among them, emphasized the importance of communication between the supporters of the Bill. The main achievement of three of the policy entrepreneurs, Gozansky, Shershevski, and the *Otzma* organization, was the creation of a coalition that managed to act effectively to pass the Act, managing by their combined efforts to overcome the main obstacle every entrepreneur encounters: the lack of power to realize their initiative on their own. Nonetheless, this coalition was unique. It was not defined as a coalition, neither by its participants nor by outsiders. No meetings were held that were attended by all of the coalition's members and only them, but instead, there were only many and frequent meetings in which two of the three actors participated, in different combinations. Despite this, all three managed to carry out a coordinated agenda, and may, therefore, be viewed as a coalition de facto.

The coalition is also unique in that its three members belonged to three different sectors: Gozansky from the legislative branch, Sharshevsky from the executive branch, and *Otzma* members from a civil society organization. This **trans-sectorial coalition** had many advantages, but it did make communication between them both highly important and highly complicated. It was important because there were no regular channels of communication, but at the same time complicated because they were often required to work around senior organizational figures who, though not part of the coalition, were the ones with the authority to meet with figures outside their organization. Many of those interviewed emphasized the importance of the informal communication channels, such as meeting at cafés and sending junior representatives to the meetings, to circumvent the obstacles and maintain coordination within the coalition.

This is where Prof. Shani's role was crucial. Shani's unique character, the fact that he did not hold an official office but had previously served as director-general of the Ministry, and the connections and prestige attached to that position, allowed him to create particularly effective alliances. His formal background enabled him access to power foci, whereas his informal position at the time allowed him to communicate free of organizational commitment. Thus Shani was able to recruit support for the Bill among a variety of high officials at different Ministries, representing various political affiliations.

Leadership by example – The manifestation of this characteristic is less obvious in the context under discussion, and was expressed differently by the various policy entrepreneurs. Shershevski and Shani exhibited a quintessential display of leading by example. The creation of rehabilitation institutions outside the framework of the Bill, first by the Rehabilitation Division, and then, on a wider scale, as part of the Act's pilot, greatly strengthened the legislative process, as it proved that rehabilitation is possible, its impact on patients is positive and it is economically logical. A truly clear display of leading by example was the creation of the pilot program, led by Prof. Shani. Shani did not wait for the policy to be enacted but strove to implement it on a limited scale immediately, proving its feasibility and greatly contributing to its passage into Act.

In the case of *Otzma*, it was the lack of leadership by example that proved to be most beneficial. *Otzma* is a non-profit organization, which engages in advocacy and policy. It does not provide services. Both members of the organization and those who were not, stated in their interviews that this was, in fact, an advantage. Other families' organizations, those that did engage in providing services, were bound to the organizational interests dictated by their funders. The market demands, generated by the fact that they provided services, also limited their actions, and such organizations could not wage the struggle for the Bill as they wished. The *Otzma* organization, on the other hand, was able to act effectively, with its sights set firmly on the best interests of the patients at all times, as they were untethered to any material interest.

As we can see, the first three criteria cited by Mintrom and Norman were fulfilled completely by these three policy entrepreneurs, while leading by example was only partially fulfilled. Mintrom and Norman argue that "When they lead by example […] agents of change signal their genuine commitment to improved social outcomes. This can do a lot to win credibility with others and, hence, build momentum for change" (Mintrom & Norman, 2009, p. 653). We can see how leadership by example did indeed deliver a message regarding the commitment of Yechiel Shershevski and Mordechai Shani, and how it was the very absence of it that lent credibility to the position of the *Otzma* organization. Because it did not engage in providing services, the other actors recognized that the organization was concerned solely with the best interests of the patients. A discussion of the possible reasons for the differences regarding leadership by example exceeds the bounds of this article, but it seems that a clue to the answer may be found in the position of the different actors – establishment actors vs. outsiders.

To demonstrate the complex interaction between the circumstances

and the actions of policy entrepreneurs, as described by Mintrom and Norman, we can use the case of the Ministry of Finance's position as an example. At the start of this chapter, we noted that the Ministry of Finance's support for rehabilitation solutions played an important role among the circumstances enabling the actions of the policy entrepreneurs. But as noted, this support stemmed, at least in part, from the actions of the policy entrepreneurs themselves, especially Yechiel Shershevski and Mordechai Shani. Two features of the entrepreneurs' actions influenced the Ministry of Finance's position in particular: the ability to define the problem in terms of rehabilitation, with an emphasis on the economic potential of such intervention, and team-building, which manifested by building constructive relationships with key figures at the Ministry of Finance.

Therefore, the complex interaction between the circumstances and the actions of policy entrepreneurs led to two policy entrepreneurs recognizing the potential support of the Ministry of Finance for a legislative move; their actions turned the potential support into actual support; the actual support, in turn, is what enabled the policy entrepreneurs to act in order to recruit the support of the upper-management at the Ministry of Health, which led to the passage of the Act.

5. Conclusion

As we have shown, the case study of the rehabilitation reform in Israel reinforces most of the literature's observations on policy entrepreneurship. The two main points in which our research strengthens the existing literature are the role of policy entrepreneurs in situations where the forces that promote change and the forces that obstruct it are balanced, and the four characteristics of entrepreneurs as identified by Mintrom and Norman.

In several points, though, our findings disagree or expand the existing research.

First, we chose to include *Otzma*, an advocacy group, as a policy entrepreneur. This is an unorthodox choice, as previous authors refrained from referring to groups or organizations as entrepreneurs. As Arieli & Cohen (2013, p. 241) stated: “despite the difficulty to trace policy entrepreneurship to the level of individuals, we choose to remain loyal to the mainstream definition of entrepreneurs as individuals rather than institutions. For it is essentially people, rather than organizations, who make social and political decisions.”

While Arieli and Cohen's observation is certainly plausible in most cases, we believe that the unusual nature of *Otzma* merits an exception. At the time, *Otzma* was a small organization, in which only four or five members were active in matters of advocacy. This small group worked cohesively, accepted decisions through consensus, and adopted a flat hierarchical structure, working as equals. It may not be surprising to some that all members of this group at the time were women, but this discussion too exceeds the scope of this paper.

While it was evident that *Otzma* played the role of policy entrepreneur, it is not possible to pinpoint one activist within this tight group that, by herself, fulfilled the necessary criteria of policy entrepreneurship. We believe that in this specific case, defining the entire group as a policy entrepreneur is more accurate than pointing to an individual.

A second point in which our analysis expands existing knowledge is the importance of trans-sectorial coalitions of policy entrepreneurs. The initial coalition that promoted the legislation included three policy entrepreneurs from three different sectors: Gozansky from the legislative branch, Sharshevsky from the executive branch, and *Otzma* from representing civil society. In our analysis we have shown how this trans-sectorality infused the coalition with potency and flexibility, enabling it to bypass organizational barriers. In our understanding, the importance of trans-sectorial coalitions of policy entrepreneurs was not discussed previously in the research literature.

Finally, our research sheds light on the nature of leadership by example, and also on its limitations. As we have shown, for some of the entrepreneurs (Sharshevsky and Shani), leadership by example was central to their success. However, for others – in our case, *Otzma* – refraining from supplying services, that is, the lack of leadership by example proved to be a source of power.

Our research points to a need for a more nuanced discussion of leadership by example. In our case, it seems that while it helps entrepreneurs from the executive branch, it may prove harmful for those from advocacy organizations. Obviously, more research is needed to clarify this point.

To summarize, the purpose of this paper was to expand our understanding of policy entrepreneurship through the examination of its appearance in the field of mental health policy, through a case study of the rehabilitation reform in Israel. We believe our findings largely support and strengthen current knowledge while expanding our understanding of several points in the theory of policy entrepreneurship.

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