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The Impact of Mental Health Reform on Mental Illness Stigmas in Israel

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ABSTRACT

This study examined public perception of stigmas relating to mental illness six months after a reform, which integrated mental health care into primary care in Israel. The results reveal that the public feels uncomfortable seeking referral to mental health services through the public health system, with Arab Israelis and men expressing lower levels of comfort than did Jewish Israelis. The current reform has not solved the issue of public stigma regarding mental health care. The study suggests that the current reforms must be accompanied over time with appropriate public education regarding mental illness.

INTRODUCTION

In 2001, the World Health Organization (WHO) recommended shifting mental health care away from large psychiatric hospitals and integrating mental health care into general health services in the community. These recommendations were intended to increase the availability of mental health services, increase efficiency and decrease costs through the use of shared infrastructure (WHO/Wonca, 2008).

The model of integration of mental health care into primary care has been introduced in several countries worldwide (Adelsheim, 2014; WHO/Wonca, 2008). Collaboration between mental health services and primary care clinics has been show in western countries to result in a faster and more sustained improvement in patients' mental health status (Levine, McCarthy, Cornwell, Brockmann, & Pfeiffer, 2017) and a rise in mental health services utilization (Bohnert, Pfeiffer, Szymanski, & McCarthy, 2013). A report by WHO/Wonca (2008) showed that integrating mental health services into primary care generated good health outcomes at reasonable costs in twelve countries. These findings might indicate certain openness among the general public towards utilizing mental health services.

Stigma relating to mental illness is widespread worldwide (Angermeyer, Matschinger, & Schomerus, 2013; Clement et al., 2013; Parcesepe & Cabassa, 2013; Semrau, Evans-Lacko, Koschorke, Ashenafi, & Thornicroft, 2015) as well as in Israel (Ben Natan, Drori, & Hochman, 2015). Therefore, one of the main objectives of the integration of mental health care into primary care services was to reduce the stigma associated with mental illness. Public perception of stigma relating to mental illness refers to a set of negative attitudes and beliefs that motivate individuals to fear, reject, avoid, and discriminate against people with mental illness (Corrigan & Penn, 1999). Stigma leads to low levels of hope, self-esteem, self-efficacy, and quality of life in people with mental illness (Mittal, Sullivan, Chekuri, Allee, & Corrigan, 2012). In addition, stigma may decrease help-seeking behavior from a mental health professional (Blais & Renshaw, 2013; Mittal et al., 2012; Reynders, Kerkhof, Molenberghs, & Van Audenhove, 2014), and as a consequence, lead to worsening health outcomes (Shim & Rust, 2013).

Integration of mental health services into primary health care was expected to reduce public perceptions of stigma relating to mental illness. It has been argued that in this integrated model, people with mental illness would be treated in the same way as people with other conditions. They would stand in the same queues, receive appointments in the same way, and be treated at the same primary health care clinics and facilities (The WHO, 2001).

This study specifically examined integration of mental health care into primary care by looking at the health system in Israel as an example. Israel has a national health insurance system that provides universal coverage for all citizens and permanent residents. Medical coverage is administered through four competing, non-profit “illness funds” (“kupot-holim”), which function similarly to traditional Health Maintenance Organizations (HMOs). Individuals are free to choose from among the four competing funds, which must provide their members with access to healthcare services. Patients cannot be denied coverage on the basis of pre-existing conditions, age, gender, occupation, or any other factors. Most primary health care services are carried out at local multi-disciplinary primary care clinics run and administered by the illness funds. It is a “one stop shop” model, providing patients with access to primary care physicians, specialists, nurses and

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lab facilities all at a single, integrated location. Some larger clinics even include physical therapy centers and minor outpatient surgical facilities. However, until July of 2015, the provision of mental health care was carried out separately from the regular, illness fund administered public health system (Davidovitch, Filc, Novack, & Balicer, 2013; Rosen, Waitzberg, & Merkur, 2015).

Prior to the 2015 reform, mental health care was under the legal responsibility of the Ministry of Health. As a consequence, the Israeli mental health system functioned separately from its physical health system in terms of financing, planning, organization, and practice setting. Psychological and psychiatric services were also available privately and separately from the Ministry of Health administered mental health care system. Following the major reform in July of 2015, mental health services were removed from direct administration by the Ministry of Health and instead added to the set of services that the public health system illness funds must provide to their members (Rosen et al., 2015). Since the reform, Israeli citizens and permanent residents are entitled to receive mental health care services through their chosen illness fund, with the costs of care covered by the funds. Individuals are also still free to choose to refer to mental health care services in the private sector, at their own expense.

Since the enactment of the 2015 reform, a patient seeking mental health services must refer to his primary care clinic in order to obtain a primary care physician's referral for mental health services. Despite the precise date of the official enactment of the reform, the change in the healthcare system has been gradual, with preparation and adjustment of staffing, resources and infrastructure during a three-year period preceding the enactment of the reform (Rosen et al., 2015). Moreover, the reform has been accompanied by public debate and large campaigns by the Ministry of Health and the illness funds, the purpose of which was to inform the public of the reform, its impact on patients, and their rights under the new conditions. This information was made available through the official websites of the Ministry of Health, the four illness funds, and through television, print and radio based media (Davidovitch et al., 2013).

Israel's 2015 mental health reform had both supporters and opponents. Supporters claimed that the integration between services would decrease the public perception of stigma relating to mental illness, while opponents argued that the provision of mental health services via the illness funds may actually discourage patients from seeking services, due to patients' potential concerns regarding privacy when seeking treatment at a neighborhood primary care clinic (Even Tzur, 2011). A question seldom addressed however is: how can mental health nurses effectively challenge stigma? (Bates & Stickley, 2013).

The purpose of the present study was to explore the characteristics of the public's perception of stigmas relating to mental health care in Israel, following the enactment of the 2015 mental health reform. By doing this, it contributes to an improved understanding of the situation facing nurses who aim to reduce stigma and to encourage a new approach to reducing its impact upon the lives of people with mental health problems.

METHODS

DESIGN

The present study is a quantitative cross-sectional survey study.

SAMPLE

A convenience sample of 200 adults took part in the study. Inclusion criteria were Hebrew-speaking adults, aged 18 and older. The participants were recruited by the researchers. Questionnaires were distributed in central Israeli cities. Participants filled out questionnaires and returned them to the researchers. Each questionnaire took approximately 15 min to complete. Participants were assured of confidentiality and that the study results would be used for research purposes only.

INSTRUMENTS

The study instrument was a questionnaire comprised of 4 parts and including 39 items. Parts 1 through 3 examined the study's independent variables. Part 1 explored sociodemographic characteristics and past experience with mental health services (12 items). Part 2 of the questionnaire explored participants' beliefs about people with mental illness. It was comprised of 16 items, adapted from the Community Attitudes to Mental Illness questionnaire (CAMI) (Taylor & Dear, 1981) (e.g., “Mental illness is a condition like any other medical condition”). Responses for these items were ranked on a Likert scale of 1 (strongly disagree) to 6 (strongly agree). Part 3 of the questionnaire explored participants' attitudes towards people with mental health problems. It was comprised of 5 semantic differentials, adopted from the Attitudes Towards Acute Mental Health Scale (ATAMHS), which was developed by Baker, Richards, and Campbell (2005) (e.g., “A person with mental illness is dirty-clean”). The semantic differentials were scored on a 1–6 scale. A higher score represented a more positive attitude. We used the versions of the CAMI and ATAMHS tools which had been translated into Hebrew. These versions had been used in a previous research study in which they achieved good internal reliability (α Cronbach = 0.72) (Drori, Guetta, Ben Natan, & Polakevich, 2014). Permission to use the Hebrew instrument was obtained from these authors. In the present study, the tools achieved a similar internal reliability: α Cronbach 0.72 for the CAMI and 0.78 for the ATAMHS.

Part 4 - of the questionnaire explored participants' readiness to seek mental health services via their illness fund- this was the study's dependent variable (e.g., “In case of need, I will feel comfortable referring to the illness fund to receive psychological services”, 3 items, α Cronbach = 0.94) and their preference to seek mental health services through the private sector (e.g., “In case of need, I will prefer to seek psychological services in the private sector”, 3 items, α Cronbach = 0.91). Part 4 was designed for the purpose of the present study. Responses for the items were ranked on a Likert scale of 1 (strongly disagree) to 6 (strongly agree).

PROCEDURE

The study was approved by the Helsinki Committee of a large psychiatric hospital in northern Israel. Informed consent to participate in the study was obtained from all participants. Each of the participants was assured confidentiality. Questionnaires were distributed by the researchers. Data were collected during January–February 2016.

STATISTICAL ANALYSES

For the purposes of the statistical analyses, Spearman correlations and *t*-tests for independent samples were used. Statistical significance was set at $p < 0.05$.

RESULTS

SOCIODEMOGRAPHIC CHARACTERISTICS

Two thirds of the participants were women ($n = 125$, 63%), and the average age was 26.3 (SD = 6.33, range = 18–57). Most of the participants were single ($n = 140$, 70%), with one child on average (SD = 1.26, range = 0–6). Most of the participants were born in Israel ($n = 176$, 88%). Half were Jewish Israelis and half were Arab Israelis. Most of the participants had academic education ($n = 118$, 59%). The majority of the participants had an income level below ($n = 85$, 44%) or equal to the average income in Israeli households ($n = 80$, 41%).

Most participants ($n = 186$, 93%) reported they had not previously