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Attitudes, Knowledge and Preferences of the Israeli Public Regarding Mental Health Services

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Abstract: We examined the public's preferences regarding the site of provision of mental health care and the basis for those preferences. A representative sample of the adult Israeli population (N=1,583) was interviewed by telephone about their knowledge and attitudes. Self-referral to mental health professionals and primary medical doctors for milder disorders was low. Psychiatric clinics were preferred by 46% of the public; 35% preferred the general clinics, and the remaining 19% were indifferent. Quality of care was noted by 78% of respondents for their preference for psychiatric clinics. General hospitals were preferred for psychiatric inpatient care by 51% of the respondents compared to 23% who opted for psychiatric hospitals. Despite reasonable familiarity with mental health care, one-third of the respondents did not know whether there was a clinic in their neighborhood. Implications for action are discussed in light of the transfer of responsibility for psychiatric care from the Ministry of Health to the health maintenance organizations (HMOs).

Significant developments in mental health care and rehabilitation have taken place in recent decades (1, 2). However, their benefit remains limited since not all individuals who need care receive it (1, 3–6). Recently, Levinson et al. confirmed these worldwide findings for Israel with regard to the common mental disorders (7). Seeking care for psychotic disorders may constitute an exception, at least for Jews born in Israel (6). Failure to receive timely and appropriate treatment might have adverse consequences, e.g., it may lead to a more severe situation (3, 8) and to the overuse of general medical services (9–11).

What impedes the receipt of care? Obstacles — e.g., financial constraints, lack of services, limited knowledge about the existence or nature of treatment, the potential service user's beliefs, and stigma (3, 4, 12, 13) — may be classified on the basis of their derivation from two main factors: the *objective* and the *subjective* availability and accessibility of services. In the absence of either factor, the individual will not seek care

Objective availability of services indicates whether services exist. Obviously, their mere existence does not suffice. High costs, a long waiting list, or too distant a location would render the services essentially inaccessible to the potential user. The importance of objective availability notwithstanding, this article will address other issues seldom covered in the local literature, namely, three aspects of subjective availability.

Goals

This inquiry has several goals. The paper addresses three aspects of *subjective availability*: (1) *subjective accessibility* (as expressed, for instance, in knowledge, perceptions and *cognitive accessibility*); (2) *preferences*; (3) *stigma*.

First, we explored the *subjective accessibility* with regard to mental health services in the Israeli public. This composite construct includes both *knowledge* and *perceptions* about the existence and cost of services — and *cognitive accessibility*. For example, if a service exists but the public does not know it, then in practical terms it is not accessible (i.e., it is subjectively inaccessible). Similarly, if a service is free of charge, but the public believes it is not, it will be subjectively inaccessible, regardless of its objective availability. *Cognitive accessibility* to receiving care refers to the degree to which a concept is accessible in the

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individual's mind and memory (14). This may be expressed in the tendency to seek professional care for different mental conditions.

Secondly, we explored an additional aspect of the construct of *subjective availability* in the Israeli public, namely, preferences with regard to care. The degree to which services suit the individual's preferences may affect their subjective availability. Clearly, if services are unavailable, subjective accessibility has little meaning. However, when services do exist, as is usually the case in Israel, it is important to examine subjective accessibility in order to improve their use. The imminent implementation of the Psychiatric Reform, which includes the transfer of responsibility for ambulatory services from the Ministry of Health to the four HMOs (15), further buttresses the importance of this inquiry. Sound planning that assures the best match between the users' preferences and the services strengthens people's willingness to seek care and reduces premature cessation of treatment. Accordingly, we explored structural aspects of the delivery of care, such as different models of service provision. This we achieved by depicting the public's preferences and reasons for the location of mental health care provision. Specifically, we first examined whether, keeping service costs equal, people would prefer to receive care in private or public settings. Second, we examined whether the public would prefer to attend a specialized (psychiatric) clinic or a general (multi-specialist) clinic. Third, we examined the public's preferences regarding the locus of the provision of inpatient care — psychiatric or general hospitals. Lastly, we examined the public's preferences regarding the distance from home to selected rehabilitation units (hostels), should the respondent or a family member need them (16).

The final aspect we explored in this study was mental-health related stigma, as it may be reflected in both aspects of subjective availability examined in this paper (i.e., subjective accessibility and preferences regarding care). Stigma directed at persons with mental problems often extends to treatment settings, psychotropic medications and caregivers (4, 17). While the individual who receives care in a psychiatric setting may enjoy its positive results, he or she has to face the associated negative effects of stigma — including the deleterious social effects of labeling and possible damage to self-esteem (3, 18). As a result, the willingness to define a problem as mental and to seek and receive care may be weakened. The dilemma is even greater when the problem is concealable (19). Studies have shown that stigma can lead to the avoidance or deferral of care or even to its premature cessation (1–4, 20–23). Thus, stigma may be reflected indirectly both in one's cognitive accessibility and in one's preferences regarding mental health care.

Methods

The sample. This study was based on a representative sample of Israel's population aged 22 and older (N=1,583). The sampling framework was a CD-Rom list of telephone numbers provided by the country's leading telecommunications company. We included Arab neighborhoods within the municipal boundaries of Jerusalem and Jewish settlements outside of the 1967 "Green Line." In each household, all adult members were listed in order of birth and selected in a successive fashion according to the household size, as follows: for the first household with three adults, the interviewer selected the oldest one. In the next 3-adult household, the second oldest was selected, and in the third similar household, the youngest adult was selected. The sample was representative of the country's residents within the selected age bracket, excluding institutionalized individuals and people who could not be interviewed by telephone (e.g., deaf-mutes or persons with no telephone), or who could not speak Hebrew, Arabic or Russian. To reduce the chance of sampling error, weights were used to adapt the sample to the distribution of the population according to the 2002 end-of-year data obtained from the Central Bureau of Statistics, while preserving the size of the sample. The response rate was 84% of those who were contacted.

The questionnaire. The questionnaire included socio-demographic items; questions regarding the preferred location for the provision of mental health care; payment for public care; existence of medications to treat depression, schizophrenia and anxiety; and acquaintance with mental health clinics, people who had undergone treatment, and with any psychiatric hospital, hostel or sheltered employment facil-

ity. Lastly, respondents were asked about their own experience with mental health care. The original Hebrew questionnaire was translated into Arabic and Russian and back-translated to check for accuracy. Test-retest reliability was examined by asking the same factual questions to 340 respondents within the span of two-to-eight weeks. The discrepancies amounted to 3% for marital status and 4% for age, inclusive of real changes. (The Hebrew questionnaire can be obtained from the first author.)

Procedure. The interviews were conducted between January and April 2003 and were preceded by a letter from the director-general of the Ministry of Health. Informed consent was obtained at the beginning of the interview. The study was approved by the Jerusalem Mental Health Center Kfar Shaul-Eitanim Helsinki Committee. (See ref. 16 for additional information on methods.)

Analysis

We compared frequencies and ratios, employing χ^2 and Z-tests for proportions. Significance levels are reported. Due to the large number of cases, we also provide an effect-size measure — Cohen's d — as caution is required in referring to significance. This measure is especially informative as it facilitates comparisons across tables and samples. Cohen's d has no upper limit. Values of .20, .50, and .80 represent small, moderate and large effects, respectively (24, 25).

Results

Demographic data. Table 1 presents the sample's distribution by gender, age, country of birth, education, marital status, religion and income.

Exposure, Knowledge and Perceptions Regarding Mental Health Care

Exposure to mental health care. The respondents' direct or indirect experience with mental health care provides a background to understanding their knowledge and perceptions regarding the existence of services. Half (50%) of the respondents reported knowing someone who was undergoing or had undergone mental health care, while one-fifth (21%) had considered seeking care. Of the 21%, one-third reported never having sought care, whereas about two-thirds (14% of all respondents) had been in psychotherapy at least once (43% of them, or 6% of all respondents, had been in therapy for more than six months).

Table 1. *Study Sample by Demographic Characteristics (N=1,583)*

		N	%
Gender	Men	761	48.1%
	Women	822	51.9%
Age group	22–29	281	17.8%
	30–39	405	25.6%
	40–49	293	18.5%
	50–59	260	16.5%
	60–69	187	11.8%
	70+	153	9.8%
Country of birth			
	Israel	970	61.3%
	Former Soviet Union	281	17.8%
	Other	332	20.9%
Marital status	Single	258	16.3%
	Married	1095	69.2%
	Divorced/separated	111	7.0%
	Widowed	114	7.2%
Formal education (yrs)			
	0–8	138	8.7%
	9–12	582	36.8%
	13–14	218	13.8%
	15+	644	40.7%
Religion	Jewish	1318	83.3%
	Muslim	158	10.0%
	Christian	57	3.6%
	Druze	35	2.2%
	Other/None	14	0.9%
Household income*			
	Under average	806	50.9%
	Around average	372	23.5%
	Above average	311	19.6%
	No response	93	5.9%

* The average household income today (2003) is about NIS 11,000. Household income includes the total income of all those who live in the household (including pensions, rent, social security benefits, etc.).

Psychotropic medications. We found relatively high awareness of the existence of medication for depression (83%) and anxiety (85%), but it was considerably lower for schizophrenia (55%). Exposure to psychotropic medications was not necessarily related to having undergone mental health care. About 13% of the respondents had taken medication to improve their mood or tranquilizers, possibly prescribed by a family physician. Cross-tabulation of psychotherapy and medication revealed that 8% of all respondents had taken psychotropic medication, 9% had been in psychotherapy, and 5% had received both. The remaining 78% had not been exposed directly to either of them.

Perceived existence of a clinic in one's area of residence. Fifty-seven percent of all respondents thought that there was no mental health clinic in their area of residence; 12% thought that there was one; and 31% were not sure.

Payment. Individuals who fear they may be unable to pay for care are likely to be less willing to seek treatment. About half, 52%, of all respondents believed that services provided in a public setting were free of charge, about 19% did not know, and the remaining 29% believed that these services did incur a fee (12% thought that it amounted to NIS 20–100; 8% over NIS 100; and 9% were unsure of the cost). About 41% reported that they could not afford mental health care. Cross-tabulation of fees and personal affordability items (the questions were not asked consecutively) revealed that about 50% of the respondents who believed they would not be able to afford treatment also believed that public care was free.

Cognitive accessibility. Under what circumstances does the public tend to seek professional mental health care? We asked a number of open-ended questions that differed in their conceptualization to examine the extent to which the *idea* or *possibility* of seeking professional mental health care was cognitively accessible. Respondents were asked to whom they would turn if they were in a very bad mood or disturbed by tension, anxiety or nervousness. Table 2 shows that the percentage of respondents who would seek help from a mental health professional at their own initiative was low (13%) and similar to the percentage who would go to their general practitioner (14%). About 41% would seek help from their social support network.

When we compared respondents living in Arab-Israeli localities to those living elsewhere, we found that the social support network was mentioned more frequently by the former (58%) than by the latter (39%, Z=6.5, p<.001). Ultra-Orthodox Jewish respondents did not differ from other Jewish respondents with respect to their tendency to seek help from the social network. Among the ultra-Orthodox Jewish respondents, the frequency with which the rabbi, the general practitioner (GP) and the mental health professional were mentioned was similar (12%, 13% and 13% respectively). (See ref. 16 for a more detailed report on these findings.)

Table 2. *Where or to Whom Would Respondents Turn if They Were in a Very Bad Mood or Suffering from Disruptive Tension, Anxiety or Nervousness (N = 1,583)*

Potential Source of Help	N	%*
Family or friends**	**650**	**41**
Spouse, other relative	485	31
Friend	244	15
Mental health professional**	**211**	**13**
Psychiatrist	51	3
Psychologist	136	9
Social worker	9	<1
Other (mental health clinic/professional)	33	2
General practitioner	**221**	**14**
Clergyman (rabbi, qadi or sheikh, priest or pastor, other)	27	2
None of the above**	**537**	**34**
God	54	3
Stated explicitly they would not seek help	411	26
Recreational activity	30	<2
Alternative caregivers	27	<2
Crisis hotline (ERAN)	1	<1
An organization	2	<1
Use of substances (alcohol, medication, marijuana)	6	<1
Don't know	25	<2

* As respondents could cite more than one source, the percentages for each category do not add up to 100.

** The bold numbers refer to respondents who cited one or more of the items in the category.

We also examined what would happen in a hypo-

thetical situation in which there was an indication for referral. We asked respondents to whom they would prefer to turn (psychiatrist, psychologist or social worker) if their general practitioner indicated that their condition necessitated mental health care. Thirteen percent reported that they would not seek professional help; about half (45%) of those willing to seek professional help would see a psychologist; 15%, a psychiatrist; and 12%, a social worker. Nine percent reported that they would leave the choice to their GP. The remaining 8% did not know the difference among the professionals or had no preference.

Preference for the setting of care

Public versus private care. The percentage of people who do not seek psychiatric treatment because they would prefer private care but cannot afford it is not known. Understanding the preference for private care may indicate how the public system could better meet those people's expectations. We asked respondents, "If you needed mental health care and the costs were the same whether provided privately or by your HMO, would you prefer to receive care privately or through your HMO?" Fifty-seven percent reported that they would prefer to receive private care; 21% would prefer to receive it through their HMO; and 22%, had no preference.

Respondents' preference for private over public mental health care was stronger in non-Arab localities than in Arab localities (59% and 47% preferring private care, respectively, Z=4.04, p<.001) (see ref. 16).

Why do members of the public prefer private care? Table 3 shows that the respondents' preference was based primarily on its perceived quality (e.g., better treatment, a caring practitioner), but was also due to confidentiality. In contrast, respondents who would prefer to receive care from their HMO based their choice on its quality (though to a lesser degree than the respondents in the former group), convenience (proximity, familiarity), and the fact that the quality of care is monitored. The pattern of reasons for preferring a particular setting (i.e., private vs. HMO) for psychiatric care was similar to that given by these respondents regarding physical care (see ref. 16).

Specialized versus general clinics. Often planners deliberate whether to provide mental health care at psychiatric or at general clinics. Some expect the latter to be associated with less stigma, because the reason for the visit would not be identified. It appears that this preference is not widely held by the public itself. Of 1,502 respondents, 46% reported preferring a psychiatric clinic; 35% a general clinic; and 19% said they had no preference.

Table 3. *Reasons for Preferring Private Mental Health Care Provision to a Public (HMO) Setting: Percentages and Proportion Comparison Test**

Reason for Preference	Preferred Type of Care Provision				
	Private (%) N = 902	HMO (%) N = 337	Cohen's d d	p	Z
Faster treatment	15	7	.23	.001	3.94
Better care — a higher professional level	47	29	.33	.001	5.78
Practitioner is more caring and attentive	32	8	.51	.001	8.66
Quality of care is monitored	3	15	.48	.001	8.19
Choice of practitioner	10	5	.17	.003	3.03
Greater confidentiality	22	>1	.54	.001	9.15
Simpler bureaucracy	3	3	–	NS	0.20
Closer/easier access	>1	9	.45	.001	7.72
Habit/unfamiliar with private care/member of health plan	0	25	.99	.001	15.63

* The percentage is calculated on the basis of total respondents preferring the respective type of care provision.
As respondents could cite more than one reason, percentages do not add up to 100. The percentages refer to the number of respondents who cited a particular reason. These reasons were not chosen from a list. They were brought up by the respondents, who were allowed to cite more than one reason. As a result, the percentages in each column do not add up to 100.

Table 4. *Reasons for Preferring Specialized Mental Health Clinics or General Clinics: Percentages and Proportion Comparison Test**

Reason for Preference	Preferred type of care provision: Psychiatric Clinic (%) N = 674	General Clinic (%) N = 487	Cohen's d d	p	Z
Quality of Care**	**78**	**19**	**1.43**	**.000**	**19.78**
Better care, higher professional level	69	13	1.35	.001	19.05
Practitioner more caring and attentive	6	2	0.23	.001	3.80
Quality of care is monitored	6	4	0.14	.02	2.31
Faster treatment	3	2	0.09	.09	1.61
Confidentiality**/Privacy	**23**	**30**	**0.16**	**.01**	**2.65**
More privacy	16	12	0.11	NS	1.90
Less chances to meet acquaintances	4	2	0.12	.04	1.98
No one will know I'm in treatment (concealment)	4	18	0.49	.001	8.11
Choice and Availability of Physicians	**2**	**44**	**1.23**	**.000**	**17.80**
Can see other physicians	<1	40	1.20	.001	17.56
Can choose my physician	2	4	0.17	.01	2.92
Convenience**	**2**	**12**	**0.44**	**.000**	**7.35**
Feel comfortable (also: to be in a healthy environment)	1	6	0.30	.001	4.90
Place is familiar	<1	5	0.31	.001	5.14
Bureaucracy	<1	1		NS	
Closer/easier to get there	<1	1		NS	

* The percentage is calculated on the basis of total respondents preferring the respective type of clinic.
As respondents could cite more than one reason, percentages do not add up to 100.
** The bold numbers refer to respondents who cited one or more of the items in the category.

Table 4 presents respondents' reasons for their preferences. Those who preferred a psychiatric clinic most often cited quality of care as the reason (78%), while those opting for a general clinic most often reported the possibility of consultations with additional physicians as the reason (40%).

Hospitalization at a psychiatric or at a general hospital? If psychiatric hospitalization were warranted, would respondents prefer care for themselves or for a relative at psychiatric or general facilities? Fifty-one percent of 1,480 respondents reported that they would prefer a general hospital; 23% a psychiatric hospital; and 26% had no preference.

Table 5 shows the differences in respondents' reasons for their preference. Among those who reported preferring a psychiatric hospital, 91% based their choice on the quality of care. Respondents who opted for the psychiatric ward of a general hospital gave varied reasons, e.g., confidentiality, 39%; quality of care, 26%; and convenience or feeling comfortable, 32%. The latter is not based on familiarity with the clinic, rather the respondents' reluctance to be surrounded only by the "mentally ill."

Proximity to sheltered housing. When asked what their preference would be if they or someone else in their family had to live in a hostel or sheltered housing, 72% of the respondents preferred the hostel be located near their home, while 19% preferred it to be far away. This distribution remained stable when we examined respondents who reported having a relative with a psychiatric disorder and those who did not separately ($p = ns$, $\chi^2 = 0.31$). The distribution remained similar when we examined separately those who reported currently or formerly living with a person who had a psychiatric disorder and those who did not ($p = ns$, $\chi^2 = 0.32$). Results did not change when we examined those who reported having visited a psychiatric ward or hospital and those who had not ($p = ns$, $\chi^2 = 1.56$).

Table 5. *Reasons for Preferring a Psychiatric Department of a General Hospital to a Psychiatric Hospital: Percentages and Proportion Comparison Test* *

Reason for Preference	Psychiatric Hospital (%) N = 338	General Hospital (%) N = 659	Cohen's d	p	Z
Quality of Care**	**91**	**26**	**1.56**	**.0001**	**19.41**
Better (mental) care	88	15	2.02	.0001	22.45
Better physical care	4	12	0.28	.0001	4.43
Confidentiality**	**11**	**39**	**0.60**	**.0001**	**9.01**
No one will know the admission is psychiatric (concealment)	2	30	0.68	.0001	10.14
Stigma, a "bad name"	0	7	0.31	.0001	4.83
Less chances to meet acquaintances	9	3	0.29	.0001	4.45
Convenience**	**1**	**32**	**0.77**	**.0001**	**11.31**
Environment-atmosphere (not surrounded only by "mentally ill")	1	29	0.71	.0001	10.59
Place is familiar	0	4	0.14	.001	2.38
Geographic proximity		<1			
Physical surroundings		<1			
Other**	–	**10**	**0.37**	**.0001**	**5.75**
Fear (of the hospitalized)	0	2	0.15	.001	2.48
Department is open***	0	2	0.17	.0001	2.75
Depends on problem	–	1			
Situation will deteriorate (in a psychiatric hospital)	0	4	0.23	.0001	3.73

* The percentage is calculated on the basis of total respondents preferring the respective type of hospital.
As respondents could cite more than one reason, percentages do not add up to 100.
Percentage citing any reason: although respondents could cite more than one reason most cited only one, only 4.3% of those preferring a psychiatric hospital and 6.3% of those preferring a general hospital cited more than one reason.
** The bold numbers refer to respondents who cited one or more items in the category.

Table 6. *Reasons for Preferring a Hostel or Sheltered Housing To Be Proximate or Distant: Percentages and Proportion Comparison Test* *

Reason for Preference	Preferred Location of Hostel				
	Far (in %) N = 292	Near (in %) N = 1,112	Cohen's d	p	Z
Easier to visit	1	79	1.72	.0001	24.48
Family can supervise	0	22	0.49	.0001	8.83
Closeness and support of resident	0	2	0.16	.0001	2.48
Familiarity with the area, orientation	0	21	0.46	.0001	8.42
Shame (not wanting others to know)	64	0	2.29	.0001	28.24
Not wanting others to harass or cause problems	19	0	0.79	.0001	13.84
A change of atmosphere for resident	10	0	0.59	.0001	10.61
The distance/separation is good for the resident	11	0	0.61	.0001	10.90
The distance/separation is good for me	4	0	0.31	.002	5.74

* The percentage is calculated on the basis of total respondents preferring the respective location.
Respondents could cite more than one reason; number preferring that the hostel be far: 314; number preferring that the hostel be near: 1,386.

Table 6 presents the reasons for these preferences. Among those who reported preferring the hostel to be close to their place of residence, the possibility of visiting was a prominent reason, followed by the possibility of monitoring the relative's life at the hostel. In contrast, it appears that respondents who preferred that the hostel be far away were wary of stigma.

Discussion

Our results show that the public is reasonably familiar with mental health care and psychotropic medication. Indeed, half of the respondents knew someone who received treatment. Although this high proportion may raise skepticism, particularly since the percentage of respondents who did not know whether there was a mental health clinic in their vicinity was relatively high, the sample size and sampling method warrant the robustness of this finding. As for help-seeking, we found similar low tendencies to consult with a mental health professional or a general practitioner whenever respondents were bothered by very bad moods, by feelings of tension, anxiety, nervousness or agitation. The population's willingness to seek help from mental health professionals increases when the family doctor (or GP) indicates that the condition requires mental health care.

In a hypothetical situation in which private and public care cost the same, the majority of respondents would prefer private care, perceiving it to be of higher quality and more confidential than public care. We also found a preference for receiving care at psychiatric clinics rather than at general clinics; persons who expressed this preference perceived them to be more professional. Stigma (expressed in terms of concern for confidentiality and discretion) worried respondents with regard to both locations. In contrast to ambulatory care, general hospitals were considered preferable to psychiatric hospitals for inpatient care. Finally, should the respondent or a close relative need rehabilitation services, respondents preferred the services to be near home.

The Cognitive Accessibility of Mental Health Care

Knowing someone who has had mental health care tends to be correlated with a more positive attitude toward its use (26, 27). We found that a fair percentage of the public had been exposed to mental health care, whether directly or indirectly, and had familiarity with psychotropic medication for anxiety and depression — but less so for schizophrenia.

We found that 88% of respondents either did not know whether there was a mental health clinic in their vicinity (31%) or thought there was none (57%). For an individual who needs help, this may constitute a barrier. For both groups of respondents (those who think there is no clinic and those who do not know whether there is one), the clinic is subjectively not accessible. Since the researchers did not know whether there was a clinic in their vicinity, our findings focus on the perception that there is no clinic. This perception makes the clinic subjectively inaccessible.

Were there indications in our study that help-seeking is "cognitively accessible"? Do people express willingness to seek care? Did the respondents regard the professional services to be the appropriate place to turn to at times of psychological distress? The answers to these questions depend upon the specific situation, framing, conceptualization of the problem as mental and its perceived severity (28). The relationship between conceptualization of a problem and the willingness to seek help is reciprocal: an individual who is open to seeking help may more readily define a condition as a mental problem that requires help.

It appears that very bad moods or feelings of tension, anxiety, nervousness or agitation that are disruptive are perceived as conditions with which an individual must cope on his or her own (a quarter of respondents stated they would not seek help) or with the help of the social support network (over 40% of respondents). Only about one-eighth of respondents reported that they would seek help from a mental health professional and another one-eighth stated that they would seek help from a GP. A similar pattern was observed in Germany (28), when a representative sample of respondents was asked where they would seek help for depression.

Our findings did indicate that there are some situations in which an individual would seek professional help. It is not clear, however, to what extent people would not seek treatment even when it could

reduce suffering and improve functioning. The literature suggests promoting the identification and treatment of depression using different means (29) and concomitantly reducing stigma. Results reported elsewhere indicate that stigma associated with seeking treatment prevails in the public (e.g., for over half of the public, the response of the environment could be a basis for *not* seeking treatment [16]). In other words, a negative reaction from the environment is perceived as a barrier to seeking care and justification for not doing so. As elaborated below, interventions to decrease stigma in general, and perceived responsibility in particular, may be helpful in attempting to lower this barrier (30).

Preferences for the Location of Care

Cognitive accessibility may also be affected by the location of care provision. Although our findings were not unequivocal, we interpret them to mean that the cognitive accessibility of the idea of seeking care at a *public* clinic is low. Time and the scope of treatment at public clinics are often limited. In many cases, there is a heavy workload in public clinics and a long waiting list for psychotherapy (31). Some people may therefore wish to seek help at private settings. However, only a limited sector of the public can afford private care. As noted above, we found that about half of the respondents who said they could not afford mental health care, were they to need it, also assumed that public care was provided free of charge. This apparent contradiction may suggest that those respondents had considered private care only, and hence thought they would not be able to afford treatment. Thus, these respondents would *not consider using public services*, were they to need mental health care (16). To understand this better, we examined the public's preferences regarding the location of treatment provision.

At present, mental health care is provided by public services and by an out-of-pocket (private) system. Given the forthcoming transfer of responsibility for psychiatric care to the HMOs, and in light of the possibility of making the structure of mental health care provision equivalent to that of general medical care, it is necessary to acknowledge the public's preferences regarding both ambulatory and inpatient psychiatric care. This understanding would facilitate either the adaptation of service provision to suit the preferences or interventions geared to reducing the avoidance of care in time of need.

If costs of care were identical, over half of the respondents would prefer private care to public (HMO) care (the remaining respondents were divided equally between preferring the HMO and having no preference). Those who preferred private care argued that the choice was born of concern for the quality of care and for confidentiality. In contrast, those who preferred receiving care from their HMO cited convenience and quality assurance.

The assumption of responsibility for mental health care by HMOs raises an important question: should care be provided at psychiatric or at general clinics? If the site of provision does not match the public's preferences, under-use of services may result (17). One reason policymakers have considered the transfer of mental health care to general clinics is the assumption that this might lead the public to perceive mental illnesses as no different from physical illnesses, thereby reducing stigma (4, 17). Our results do not support this stand — stigma was mentioned by about one-fifth of respondents as being one of the reasons for their preference, but this claim was equally prevalent among respondents who preferred a mental health clinic or a general clinic. Moreover, the public seemed to prefer psychiatric clinics. A major reason for this preference is concern for the quality of care.

Given the evidence of stigma associated with being "mentally ill" (16), one might speculate that the preference for general clinics would reflect a desire to avoid people who are receiving mental health care, particularly those considered "mentally ill." However, this was not the case: the main considerations for preferring the general clinic were the possibility of seeing additional physicians and overall convenience. Respondents' reasons for preferring either the psychiatric or the general clinic should be heard when attempting to match services to the public's preferences.

A similar issue concerns inpatient psychiatric care, which carries more stigma than ambulatory care. Here we found that respondents prefer the general hospital. This preference is commensurate with the trend toward increasing the number of psychiatric beds in general hospitals and decreasing their number in psychiatric hospitals (32). Nonetheless,

one-quarter of the respondents would prefer to be admitted to a psychiatric hospital. As with ambulatory care, those preferring the psychiatric hospital perceive it to have greater expertise.

Lastly, we also asked respondents about their preference regarding rehabilitation in the community, including satellite housing and comprehensive hostels. Respondents expressed a clear preference for a hostel in the vicinity of their home. Chief among their reasons were the possibility of visiting the hostel and of monitoring the care of their relative.

Limitations and strengths of this study

The main limitation of this study is the lack of information on the non-responders. However, our response rate was excellent: fewer than 20% of the intended interviews were not completed. To compensate for the non-response, we adjusted our sample to the overall population by means of weighing (16). One may nevertheless speculate that those who refused the interview were characterized by more negative attitudes toward mental health. This limitation is balanced by several strengths, the large sample size, its representativeness, the theory-driven questionnaire, and, as noted above, the high response rate. Thus the overall robustness of the study provides adequate bases for policy formulation and interventions in a period of reform in the mental health system.

Recommendations

Based on the study findings, we submit the following recommendations:

Since a notable proportion of the public does not know whether or not there is a mental health clinic in the vicinity, we recommend the provision of relevant information. This may facilitate help-seeking in time of need.

We observed that, in certain situations, people are equally willing to seek help from a GP or a mental health professional and that the public is more willing to seek mental health care when their GP advises it. We therefore endorse a recommendation that has been made often: to increase GPs' awareness of their role as gatekeepers and to train medical students accordingly.

The literature suggests increasing help-seeking and self-referral by conducting public information campaigns. Among other purposes, the campaign messages should aim at reducing the responsibility of the person in need of care for the condition (30, 33, 34) and at highlighting that seeking help from a psychiatrist or psychologist is not a sign of weakness, or that there is something "wrong" with people who undergo psychotherapy. However, the extent to which campaigns indeed affect people's behavior, or whether such an effect remains constant over time, is not clear (4).

Before psychiatric care is provided by the HMOs, negotiations among users, families and providers are desirable to reach a better match between the public's preferences and the HMOs resources and policies. Attempts to reduce the avoidance of public mental health care would need to address the perception of private services as being of higher quality and more confidential, and emphasize the convenience and quality assurance offered by public services.

The majority of respondents expressed a clear preference for inpatient psychiatric care at a general hospital. A quarter of respondents who preferred psychiatric hospitals believed their level of professional competence to be higher. It may thus be useful to clarify to the public that general hospitals are capable of providing high quality care.

The public expressed preference for specialized mental health clinics, since they were perceived to be more professional. To promote consultation at general clinics, as proposed by the Psychiatric Reform, would require purposeful interventions. Concomitantly, one might emphasize the features that make the general clinic more attractive (e.g., the availability of other physicians), particularly for certain subpopulations such as the elderly, who are relatively frequent users of general medical services. Clearly, such interventions should also address the issue of confidentiality and discretion. As each group of respondents saw the advantages of its preferred type of clinic in maintaining confidentiality and discretion, interventions to change attitudes should draw on these.

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