Mental Health Services in Israel: Needs, Patterns of Utilization and Barriers. Survey of the General Adult Population

Irit Elroy ♦ Bruce Rosen ♦ Ido Elmakias ♦ Hadar Samuel

The study was funded with the assistance of a research grant from the Ministry of Health

RESEARCH REPORT

RR-749-17
Mental Health Services in Israel: Needs, Patterns of Utilization and Barriers
Survey of the General Adult Population

Irit Elroy         Bruce Rosen         Ido Elmakias         Hadar Samuel

The study was funded with the assistance of a research grant from the Ministry of Health

Jerusalem         September 2017
Editor: Revital Aviv Matok

English translation (executive summary): Naomi Halsted

Layout and print production: Anat Perko-Toledano

Myers-JDC-Brookdale Institute
Smokler Center for Health Policy Research
P.O.B. 3886
Jerusalem 9103702, Israel

Tel: (02) 655-7400
Fax: (02) 561-2391

Website: http://brookdale.jdc.org.il/
e-mail: brook@jdc.org.il
Related Myers-JDC-Brookdale Institute Publications


Reports and English summaries are available on the Institute website: brookdale.jdc.org.il
Executive Summary

Background
In July 2015, the mental health insurance reform, which transferred responsibility for the provision of mental health services from the Ministry of Health to the health plans, went into effect. At the Ministry’s request, MJB has played a key role in designing the evaluation of the mental health reform and its implementation since 2007. As part of this effort, in 2013, the Institute conducted a comprehensive survey of the general public, which examined the prevalence of need of mental health services and the care seeking patterns – topics that were essential for designing and evaluating the insurance reform.

Study Goals
♦ To present the situation in Israel on the eve of the insurance reform with regard to the extent of mental distress within the general population, patterns of seeking care from professionals, availability and accessibility of the services, and satisfaction with them
♦ To characterize the populations reporting a high percentage of mental distress, in order to identify the risk groups requiring special attention
♦ To identify the factors affecting care seeking behavior for treatment of mental distress and to identify the groups that have a lesser tendency to seek treatment even when they are in need of it
♦ To describe patterns of receiving mental health services prior to full implementation of the insurance reform as a baseline for comparing the situation after implementation
♦ To identify areas in the mental health services that could be improved.

Study Method
Between February and October 2013, MJB conducted a telephone survey of the adult population (age 22+). The sampling framework was the computerized lists of landline telephones of the Bezeq and Hot telephone/cable companies. Localities were grouped into three strata based on their socioeconomic level. Then, households were sampled from within each stratum, with an oversampling of households from the lowest SES strata. Finally, within each household sampled, one adult was sampled from among all household residents over the age of 22. Altogether, 2,246 individuals were interviewed and the response rate was 55%.

In order to achieve accurate representation, the data were weighted to reflect the sampling ratios of the strata and demographic composition of the population. The characteristics of the sample were very similar to those of the population according to data from the Central Bureau of Statistics (CBS) and the National Insurance Institute (NII). However, members of the Clalit health plans and the Arab population were underrepresented.

The study questionnaire focused on issues that could be affected by the mental health reform. They included patterns of seeking treatment for mental distress, availability and accessibility of the services, reasons for not receiving treatment and barriers preventing treatment, patterns of utilization
The study made it possible to assess the prevalence of mental distress in the general population and in various subpopulations.

The screening question used to identify people with mental distress was: "In the past 12 months have you felt any mental distress that was hard for you to cope with alone, e.g., a high level of tension, anxiety, depression or profound sadness?" The question was based on a screening question used in national surveys in Canada and the United States.¹ The face validity and construct validity were also checked in earlier studies conducted in Israel.²

**Study Findings**

**Extent and Characteristics of Mental Distress**

- **Prevalence of mental distress in the previous year:** 18% of the adult population reported that in the previous year they had experienced mental distress that was hard to cope with alone. The percentage was particularly high among those who defined their health status as "not good" (43%) or "moderate" (30%), among those with a close friend or relative who had been treated for mental distress in the previous year (29%), among the divorced and widowed (27%) and among the Arab population (25%).

- **Prevalence of mental distress over lifetime:** 26% of the respondents had felt mental distress at some time.

- **Extent of diminished functioning due to mental distress (Sheehan Disability Scale):** 55% of the respondents who reported mental distress in the previous year were found to have a functioning problem on the Sheehan Disability scale (1983), which examines the extent that mental distress has impaired daily functioning. Higher rates of functional impairment were found among those feeling distress in the Arab population (74%).


Patterns of Care Seeking

♦ 36% of those who had felt mental distress reported that they had sought professional treatment from a psychiatrist, psychologist/psychotherapist or family physician (or a combination thereof). Thirty-one percent of the respondents received assistance from informal sources (friends, family, or member of the clergy). Ten percent reported they had sought help from formal, but not medical or mental health, professionals, such as alternative practitioners or coaches and 23% of the respondents who had experienced distress in the previous year reported that they had not sought any treatment at all.

♦ 40% of those defined as having a functional problem due to mental distress sought professional treatment.

♦ The reasons for not seeking professional help: The most common reason for not seeking professional help noted by the respondents who had felt mental distress was "I wanted to deal with it on my own" (49%). In addition, a high percentage reported that they did not seek help because they did not believe that treatment would help (40%), "had no access to information" (32%), and "because of the cost" (32%). Note that respondents could indicate more than one reason; hence these figures total more than 100%.

Patterns of Receiving Professional Assistance to Treat Mental Distress

♦ Primary professional: 52% of those who sought professional assistance reported that the primary professional was a psychologist or psychotherapist; 25% were treated primarily by their family physician; and 23% received treatment primarily by a psychiatrist. Twenty-seven percent reported that they were treated by more than one professional.

♦ Framework in which professional treatment was given by the primary professional: 42% of the respondents who had received treatment in the previous year reported that they received it at their health plan, 32% received private treatment, and 26% received treatment through a state-owned or other nonprofit framework.

♦ Type of professional treatment for mental distress: The respondents were asked if the treatment they had received from the primary professional included "a personal discussion with the professional," "group therapy," "medication and follow-up," or a combination of treatments. Fifty-six percent had discussions only, and 8% were treated solely with medication. Thirty-six percent reported that the treatment from the primary professional included both discussion and medication. Altogether 44% of those who received professional mental healthcare received medication.

♦ Payment for professional treatment: 20% of the respondents who had received treatment in the previous year had paid for the treatment in full; 22% had paid partially (the remainder being covered by the insurance); 58% paid nothing at all.

♦ Waiting time for an appointment: The waiting time for the first appointment with the primary professional was found generally to be not long. Twenty-three percent of those treated in the previous year had met with the primary professional on the day they applied, or the following day. Forty-seven percent waited 3-4 days for the first meeting; 23% waited between a week and a month, and 7% waited for more than a month. The waiting times for an appointment varied by
type of professional: on the same or following day, the family physician met with 42% of the patients; psychologists/psychotherapists saw 19% of applicants, and psychiatrists, 10%.

Satisfaction with the Treatment of Mental Distress and with the Primary Professional

In answer to the question about general satisfaction with the mental health treatment they received (on a scale from 1 "not at all satisfied" to 5 "satisfied to a very great extent"), 45% of the respondents reported that they were satisfied "to a very great extent," and a further 42% were satisfied to a great extent. Satisfaction with the interpersonal aspects of the treatment was higher than with other aspects: "The professional treated me with respect and dignity" (67% satisfied to a very great extent); "gave me enough time" (63%); "I felt comfortable talking about the problem" (54%); "[I had] confidence and trust in their professional ability" (55%); and "availability of the professional for telephone advice" (55%). Satisfaction (to a very great extent) was lower for "the number of treatments during the past year" (34%); "the attitude of the clerical staff" (35%); "the treatment helped to solve the problem" (40%); "waiting time for first treatment" (40%); "cost of the meetings" (41%); and "getting through on the phone" (43%).

The percentage of respondents expressing a high level of trust and confidence in the primary caregiver’s professional ability was lower among patients of psychiatrists than among those treated by their family physician and psychologists/psychotherapists (25% vs. 48% and 71%, respectively). Similarly, a relatively low rate of patients of psychiatrists and family physicians expressed a high level of satisfaction with the amount of time devoted to discussing the problem (38% and 48%, respectively, vs. 83% among those who saw a psychologist) and the professional’s attitude toward them (44% and 52%, vs. 85%, respectively).

Identifying Mental Distress in Primary Healthcare

Respondents who reported experiencing mental distress in the previous year saw their family physician more than the others did (94% vs. 81%, respectively). However, only 10% of all the respondents and 34% of those who had experienced mental distress in the previous year reported that they discussed their mental state with their family physician. In most cases (73% of all the respondents and 80% of those who felt mental distress), the discussion was initiated by the patient.

Issues Arising from the Findings

♦ The study found extensive prevalence of mental distress in the population, but only about a third of those who experienced distress sought professional treatment from the family physician or a mental health professional. Among disadvantaged populations, the referral rate was even lower. The main reasons for not seeking treatment among the Arab population stemmed from a lack of information ("I didn't know whom to contact and where to go") and lack of availability and accessibility of the services. Hence, there is a need to provide more information and to increase the availability of the services and access to them, particularly for this population.

♦ The findings show that many of individuals experiencing mental distress felt that they did not have enough information about the treatment options and the way to apply for them and they found it difficult to "navigate" their way through the mental health system. Thought should be
given to making the information on the health plan websites more accessible to potential patients proactively through outreach, and to having a mechanism to screen patients and advise them about the help they need and where to get it.

♦ More than half of those treated by psychologists and psychotherapists (55%) reported that they were treated privately (with no subsidy). The most frequent reason for choosing the private sector was the difficulty finding a professional whom they considered suitable in the public system. Hence, there is a need to produce a sufficient supply of a variety of professionals in the public system, with emphasis on psychotherapists.

♦ The relatively low level of satisfaction with the time given to treating a mental problem among patients of physicians (psychiatrists and family physicians) demonstrates the need to re-examine the guidelines to physicians on allocating time for mental healthcare.

♦ The study found that in most cases family physicians did not initiate discussions about mental health with their patients. The rates of identification of mental distress in primary medicine could be increased by raising physicians' awareness of common "warning signals" about mental distress and encouraging screening for mental distress, including among those patients who see their physicians for other reasons. This is particularly important in light of the fact that individuals suffering from mental distress see their family physician more frequently than other patients.

♦ The study found that in the year prior to the survey one in five members of the population reported a feeling of mental distress that was difficult to cope with alone. About a third of them sought professional treatment and two-thirds sought assistance from informal sources, professionals outside of the medical or mental health professions, or forfeit help for their distress. Since resources are limited, and given these findings, it is important to set clear policy on the dividing lines between the private and public sectors for public mental health services. Inter alia, the following should be discussed:

- Who is eligible for treatment and to what extent?
- Should patients be prioritized, and if so, in what way?
- To what extent should resources be invested in dealing with barriers that impede receipt of treatment, e.g., stigma, lack of information, confidence in the treatment?
- Should there be proactive identification and outreach? And to what extent?
- Does the public mental health system need to treat patients whose distress does not meet the criteria for a psychiatric diagnosis but could develop into a pathology later?

♦ The survey raises several subjects that should be examined in greater depth in future studies:

♦ The reason why people choose to cope with mental distress alone rather than seeking treatment, particularly among those whose daily life is disrupted by the distress. In-depth characterization of persons in the group that does not seek help and their reasons for not doing so would make it possible to identify possible targets for outreach.

♦ Since the survey was conducted among the general population, only a small fraction of the
respondents had undergone psychological treatment. Consequently, it was not possible to make an in-depth analysis of the association between the characteristics of the patients, the professionals, the treatment framework and so forth, and with the respondents' satisfaction. In the future it will be important to conduct surveys that focus on people who have received mental health care, which will make it possible to conduct an in-depth examination of matters concerning satisfaction and to ascertain what contributes to satisfaction or detracts from it, as well as to examine other aspects that relate specifically to patients. In particular, the reasons for the relatively low rate of trust in the professional abilities of professionals among psychiatric patients and the reasons for the low rate of satisfaction with the interpersonal relationship skills of psychiatrists and family physicians need to be examined.

The survey raises a number of points that need to be followed up after full implementation of the insurance reform. These include: trends in treatment rates, waiting times for appointments, satisfaction, transition from the private to public sector and vice versa, and the percentages of patients receiving psychotherapy and those receiving medication.
# Table of Contents

1. Introduction  
   1.1 Background  
   1.2 Provision of Mental Health Services on the Eve of the Insurance Reform  
   1.3 Population Surveys on Mental Health  
2. Study Goals  
3. Study Method  
   3.1 Study Population and Sample  
   3.2 Sample Weighting  
   3.3 Study Instruments  
4. Findings  
   4.1 Respondents Reporting Mental Distress and their Characteristics  
   4.2 Characteristics of the Mental Distress  
   4.3 Referral for Treatment for Mental Distress and Characteristics of those Referring  
   4.4 Patterns of Receiving Professional Assistance for Treatment of Mental Distress  
   4.5 Satisfaction with the Treatment of Mental Distress and the Primary Professional  
   4.6 Reasons for Not Seeking Professional Treatment  
   4.7 Mental Health in Primary Medicine  
5. Discussion and Conclusions  
   5.1 Mental Distress and Referral for Professional Mental Health Treatment  
   5.2 Percentage of patients in the Mental Health System  
   5.3 Characteristics of Treatment Provided in Mental Health  
   5.4 Availability and Accessibility of Mental Health Services  
   5.5 Role of the Family Physician in Proactive Identification of Mental Distress  
   5.6 Satisfaction with Treatment and Primary Professional  
   5.7 Mental Distress, Referral for Treatment and Barriers in the Arab Population  
   5.8 Dividing Lines between the Private and Public Sectors in Mental Health Services  
Bibliography