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MENTAL ILLNESS STIGMA IN THE ISRAELI CONTEXT: DELIBERATIONS AND SUGGESTIONS

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ABSTRACT

Background: In this paper we deliberate mental illness stigma in the Israeli context and suggest ways to reduce it, emphasizing the community's role in the rehabilitation of persons with mental illness.
Material: A literature review of Israeli and international literature of mental illness stigma.
Discussion: Community mental health, in addition to its traditional focus on developing community-based services, should focus also on community-based interventions such as the delivery of anti-stigma interventions.
Conclusions: Providing individualized rehabilitation services in the community while addressing stigma-induced social barriers may create a better recovery ground for Israelis with mental illness.

Key words: mental illness stigma, psychiatric rehabilitation, social inclusion of persons with mental illness in Israel, strategies to reduce mental illness stigma

INTRODUCTION

'Owth' (Genesis 4:15) means a sign, omen, warning or remembrance, and refers to the biblical passage where God declared that Cain was cursed. The modern use of 'mark of Cain' labels persons with a distinguishing characteristic and, in the process, devalues them. Throughout history, the label of mental illness has similarly marked persons, and differentiated them from those without a mental illness (Gray, 2002; Angermeyer & Matschinger, 2003; Lee *et al*., 2005). This 'mark', or stigma, refers to negative stereotyped beliefs, prejudice and behaviors toward persons with mental illness. Stereotyping and prejudice, in turn, may results in barriers to consumers' access to knowledgeable health care, treatment, social resources, social inclusion and opportunities for recovery (Deegan, 1997; Wahl, 1999; Kadri & Sartorius, 2005). Negative attitudes and behavior toward persons with mental illness, which are often internalized by consumers (Ritsher & Phelan, 2004; Lysaker *et al*., 2007), frequently generate feelings of shame, guilt, low self-esteem, social dependence, isolation and hopelessness (Link *et al*., 2001; Rüsch *et al*., 2006). Moreover, underutilization of mental health services is one of the main consequences of stigma (United States Public Health Service Office of the Surgeon General, 1999; Judd *et al*., 2006). Social behaviors that stigmatize persons with mental illness may impede their willingness to use those services that they could otherwise benefit from.

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Psychiatric rehabilitation in Israel, similar to that in other countries, emphasizes support services and skills training to facilitate consumers' opportunity to set and pursue personal goals, including attempts to fulfill work, family, social and community roles (Grinshpoon *et al*., 2006). The rehabilitation services offered, however, focus almost exclusively on the person trying to recover, paying little attention to the context in which recovery occurs. Deegan (1995) has stressed the importance of not only directing efforts towards the individual's rehabilitation, but also enlarging the mainstream to accommodate persons with diverse functional capabilities, and leaves 'no one stranded on the fringes'. Hence, strategies for recovery and community integration of persons with mental illness must expand beyond rehabilitation services to include efforts to increase social inclusion and access for persons with mental illness while decreasing stereotyping, prejudice and discrimination.

In this article we review and analyze the degree and nature of mental illness stigma in Israel, and then propose how this might be addressed, while recognizing the importance of shifting from individual basis rehabilitation models to broader community models.

MENTAL ILLNESS STIGMA: A BRIEF OVERVIEW OF THE CURRENT WORLD-WIDE SITUATION

Stereotypes, prejudice and discrimination against persons with mental illness are common phenomena in western culture. For example, 75% of the American public view persons with mental illness as dangerous (Link *et al*., 1999). In a study conducted in Germany (Angermeyer & Matschinger, 2005), almost two-thirds of respondents shared the view that 'former mental patients' are disadvantaged when it comes to applying for a job or dating and over half believed that persons in German society think less of a person who has been hospitalized in a 'mental hospital'. In a Canadian survey of attitudes towards disabilities, respondents reported that, of all disabilities, they were the much less comfortable when in the presence of someone with a mental illness. For example, the greatest degree of comfort is associated with 'physical' disabilities (i.e. 80% would feel very or somewhat comfortable around someone using a wheelchair) while it is less comfortable being around persons with 'hidden' or 'internal' disabilities (i.e. 46% would feel very or somewhat comfortable around someone with chronic depression) (Canadian Attitudes Towards Disability Issues, 2004). Two-thirds of the public surveyed in Switzerland favored revoking drivers' licenses of persons with mental illness (Nordt *et al*., 2006). In a survey of consumers in the United Kingdom, 70% reported that either they or a family member had experienced stigma as a result of mental illness (Mental Health Foundation, London, UK, 2000). Of those, 56% experienced stigma within their own family, 52% from friends, 44% from their primary care physician, 32% from other healthcare professionals and 30% in their workplace. Recent studies indicate that mental health professionals hold negative stereotypes (i.e. persons with mental illness are more 'dangerous', 'unpredictable', 'unreliable', 'lazy' than the general public), stigmatizing attitudes (i.e. low expectations about long outcomes and prognosis), and display a high level of social distance (i.e. unwillingness to interact with/live next to/marry/have children with a person with mental illness) toward persons with mental illness (Caldwell & Jorm, 2001; Lauber *et al*., 2006; Nordt *et al*., 2006). In some studies, mental health professionals displayed the same or higher levels of negative stereotypes and social distance toward persons with mental illness than the general public (Van Dorn *et al*., 2005; Nordt *et al*., 2006).

As a result of the growing awareness of how common and universal stigma is, along with a growing appreciation of its devastating consequences, advocacy groups and anti-stigma programmes around the world have increased (Sartorius & Schulze, 2005; Read *et al*., 2006; Saxena *et al*., 2006). Well-known campaigns are those in Australia, the United Kingdom, the United States, Canada, New Zealand, and the Global Program against Stigma and Discrimination Because Of Schizophrenia, launched by the World Psychiatric Association (WPA) (Vaughan & Hansen, 2004; Pinfold *et al*., 2005; Sartorius & Schulze, 2005; Wittwer, 2006).

As evident from this brief review, stigma is, unfortunately, a common and widespread phenomenon. There is, however, an increasing awareness and appreciation of its devastating consequences, and a growing effort to combat it. Next we will discuss the current situation in the mental health field in Israel.

CURRENT STATUS OF PROGRAMS IN ISRAEL – THE COMMUNITY'S ROLE IN THE REHABILITATION AND RECOVERY PROCESS

In Israel, the public's awareness of mental health issues, and the stigma attached to it, has increased in recent years. This increase happened mostly due to mental health reforms, such as shifting the locus of care from psychiatric hospitals to care in community-based facilities and the growing number of mental health rehabilitation services in the community (Aviram, 1996; Grinshpoon *et al*., 2006; Aviram et al., 2007). More Israelis with mental illnesses are living in the community, and can make use of rehabilitation services for supportive education, supported employment and housing in the community (Grinshpoon *et al*., 2006).

This positive shift towards growing community services strengthened the community's influence on the rehabilitation process, and the recovery and social inclusion of persons with mental illness. However, Israeli mental health services focus almost exclusively on one side of the equation, namely on interventions for consumers. There is an unmet need in Israel to integrate lessons learned from anti-stigma programs in other locations into the rehabilitation process to overcome community barriers, and to increase the access to services, opportunities for integration and active citizenship for persons with mental illness.

The results of this oversight are evident in the findings from recent Israeli studies on the public's attitude and behaviors toward persons with mental illness. Studies indicate that the Israeli public holds negative, stereotyping attitudes, and that there is evidence of discriminatory behaviors toward persons with mental illness (Feldman, in press; Struch *et al*., 2007).

Struch *et al*. (2007) surveyed a sample of Israeli adults aged 21 and older to examine their attitudes toward persons with mental illness. When participants were asked which are the most common characteristics of persons with mental illness, more than 50% replied that persons with mental illness demonstrate 'bizarre behavior, language irregularities and unkempt personal appearance'. Eighty percent mentioned that persons with mental illness are 'unpredictable'. Moreover, while 64% agreed that persons with mental illness can work, 58% thought that they *cannot* work in a normal job, such as a bank clerk. Behavior patterns revealed the well-documented NIMBY (Not In My Back Yard) phenomenon: 40% replied that they would not want a person with mental illness living in their neighborhood; 88% said that they would not let a person with mental illness take their children to school; and 50% replied that they are willing to help a person with mental illness but are not willing to be his or her friend.

These findings indicate that the public holds negative attitudes and behavior toward persons with mental illness, which are likely to act as a major barrier in their rehabilitation process, recovery and social inclusion.

In the following section, we review the major barriers to rehabilitation and social inclusion of persons with mental illness identified in the professional literature – while emphasizing their relevance to Israeli efforts to promote access and life opportunities of persons with mental illness.

BARRIERS TO REHABILITATION AND SOCIAL INCLUSION OF PERSONS WITH MENTAL ILLNESS – WORLDWIDE AND IN ISRAEL

Israeli society is similar to that of other countries and cultures where the general public stereotypes and stigmatizes persons with mental illness, and, as a result, may block opportunities for them to assume community roles. The professional literature shows that specific groups emerge as potential barriers to promotion of mental health interventions. These groups, usually referred to as power groups, are defined as groups whose attitudes about, and behaviors toward, persons with mental illness have significant impact on their life opportunities (Corrigan, 2004). Hence, the most effective anti-stigma programmes are tailored to the specific perceptions, concerns, behaviors and contexts of the power group (Corrigan, 2004; World Psychiatric Association, 2005). Those groups are: landlords, employers, criminal justice professionals, persons with mental illness who adopt self-stigmatization, families of persons with mental illness, healthcare providers, public policy-makers and the media (Ishige & Hayashi, 2005; Pinfold *et al*., 2005; Sartorius & Schulze, 2005; Stuart, 2006a, 2006b).

First we want to refer to the Hebrew terminology for mental illness due to its potential effect on the attitude and behavior of power groups toward persons with mental illness. The Hebrew term for mental illness ('machalat nefesh') means the 'disease of the soul'. As stressed by Levav *et al*., (2005), this term is highly dissonant with current scientific concepts whereby mental disorders are recognized as bio-psycho-social entities. Using the word soul ('nefesh') may suggest that the spiritual essence of a person is affected by the psychiatric disorder and that the dreams, hopes, love and decisions of persons with mental illness are diseased (Levav *et al*., 2005; Oren, in press). The 'soul approach' may also add to the metaphysical characteristic of mental illness, an approach that is common among religious persons, both Jews and Muslim Arabs (Denny, 1988; Bilu & Goodman, 1997; Goodman, 2001; Al-Krenawi, 2002).

Landlords

Safe, reliable shelter is a basic human need. Unfortunately, many persons with mental illness are unable to obtain housing. Landlords may refuse to rent to persons with mental illness, or may block independent housing goals by not permitting reasonable accommodations. In other cases, persons from the community, and policy-makers, are blocking housing options of persons with mental illness.

In recent years the Israeli press has reported incidents where community members protested against hostels and other community-based housing for persons with mental illness. In at least one case, the protests escalated into burning and destruction of an existing hostel for persons with mental illness and retardation. Local residents have appealed to mayors and other politicians to prevent hostels in their neighborhoods. As a result of residents' pressure, some mayors promote

legislation that will limit community-based housing for persons with mental illness or with substance abuse disorders.

Employers

Holding a job provides an important opportunity to function in society as an adult, and contributes to building a social network. Moreover, a salary helps to improve quality of life, and to prevent living in poverty, a common consequence of mental illness (Henry & Lucca, 2004; Marwaha & Johnson, 2004). Unfortunately, many employers hold negative attitudes towards persons with mental illness, and as a result are unwilling to hire or provide reasonable accommodations (Scheid, 2005; Stuart, 2006a). One of the most critical barriers to the employment of persons with mental illness is the degree of social stigma and thus is connected to most employment-related problems: even though the majority of persons with mental disorders desire regular work, their unemployment rates are three to five times higher than among those without mental disorders (Sturm *et al*., 1999); consumers are concerned about losing Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) benefits; they feel embarrassed about symptoms and side effects of medications; they lack the training and skills necessary for certain jobs; and they have inculcated low expectations communicated to them from support staff and others (McQuilken *et al*., 2003).

According to the Commission for Equal Rights of Persons with Disabilities (State of Israel, Ministry of Justice, 2006), employment rates of persons with disabilities are very low when compared with the rest of the population. Persons with disabilities work more often than others in part-time positions, lower-paying occupations, and receive less professional training. Moreover, income from employment and job security are very low compared with those without disabilities. Lastly, in old age, the employment rates of persons with disabilities are negligible compared with the 20% that are employed from the rest of the population at the same ages. The National Insurance Institute report for 2005 indicates that the largest group of persons who receive General Disability Allowances are persons with psychiatric disabilities (31% of total recipients) (Annual Review for 2005, the National Insurance Institute, Chapter 5). In this large group of 50,000 persons with psychiatric disabilities, 2559 work in sheltered workshops; 2242 work in prevocational training; 1286 work in supportive employment and 37 persons work in intensive sheltered workshops (Mental Health in Israel, Statistical Annual 2006). These figures show that most of the mental health consumers in Israel work in 'shelter workshops', which involves monotonous and simple tasks, and provides little income.

Criminal justice professionals

One of the most common stereotypes of persons with mental illness is that they are likely to be violent and dangerous (Monahan & Arnold, 1996; Link *et al*., 1999; Phelan *et al*., 2000; Appelbaum, 2006). This stereotype may cause police officers to be overly defensive, and may lead to overreactions toward persons with mental illness (Watson *et al*., 2005). Moreover, officers have the power to decide whether persons with mental illness receive adequate psychiatric care, remain in their current situation or are further processed into the criminal justice system (National Counsel of State Governments, 2002). Therefore, police need specialized training to be able to recognize the signs of mental illness, and to take appropriate actions.

Lastly, when persons with mental illness are victims, they often do not report the crime (Hiday *et al*., 1999). When they do report a crime, they are often viewed as unreliable witnesses and little is done to assist them (National Counsel of State Governments, 2002).

According to the Israeli Public Defender, in recent years, police refer persons with mental illness to the criminal justice system instead of to psychiatric care. Moreover, there is an increase of court orders for admissions to compulsory ambulatory treatment (i.e. from 29 in 1996 to 108 in 2005), court observation orders (i.e. from 748 in 1999 to 968 in 2005) and court hospitalization orders (from 165 in 1999 to 295 in 2005) (Mental Health in Israel, Statistical Annual, 2006). Often, the cases that are transferred to the criminal justice system are 'easy' cases such as phone harassments and threats.

Policy-makers

Policy-makers in private and government institutions may restrict opportunities for persons with mental illness. The end results are to limit options of persons with mental illness and prevent their integration into society (Aydin *et al*., 2003).

As in most countries, including the United States, mental health in Israel is underfunded; there is an inherent discrimination in private and public health insurance (Supreme Court Petitions number 5777/05 & 4015/06); one-third of persons who are entitled by law to public mental health services do not get them; and evidence-based interventions (that is, specific treatments with demonstrated efficacy) are not incorporated into clinical practice or into community-based programs.

Healthcare providers

Stigmatization of and discrimination against persons with mental illness are common among healthcare providers, including psychiatrists, social workers and psychologists (Deegan, 1997; Gray, 2002; Lauber *et al*., 2004; Deegan, 2005; Yanos *et al*., 2007). A recent study comparing knowledge of and attitudes toward persons with schizophrenia and major depression among mental health professionals and the general public found that psychiatrists had significantly more negative stereotypes than all other groups (i.e. psychologists, nurses, other therapists and the general public) (Nordt *et al*., 2006). Moreover, professionals displayed an equally high level of social distance toward persons with schizophrenia as the general public. Bias against persons with mental illness and their families can start early in professional training programs and may lead to stigma, low expectations, infantilization and dehumanizing clinical practices, all damaging the work of recovery, healing and rebuilding consumers' lives (Deegan, 1997; Sartorius, 1998; Angell *et al*., 2005). First-person accounts of Israeli consumers describe their experiences with stigmatizing attitudes and behaviors from mental health providers. These stories describe abuses (i.e. physical and emotional) in the mental health system, dehumanization behaviors from the professional staff and a strong feeling of paternalism and lack of respect.

The media

In all media worldwide, persons with mental illness are represented as violent, dangerous, unpredictable and criminal-like (Wahl, 1995; Sartorius & Schulze, 2005; Stuart, 2006b; Sullivan *et al*., 2005;). Stuart (2006b) demonstrated that negative media images impair consumers' self-esteem, help-seeking behaviors, medication adherence and overall recovery. In contrast, the media have the potential to challenge public prejudices, initiate public debate and project positive, human-interest stories about persons who live with mental illness (Stuart, 2006b). To date no research has been conducted in Israel about this subject.

Persons with mental illness

Many persons with mental illness accept negative stereotypes and prejudices, and apply those to themselves in a process of self-stigmatization (Link & Phelan, 2001). Self-stigmatization has a profound impact on the person with mental illness, and may lead to low self-esteem, hopelessness, low self-confidence, unwillingness to seek help, treatment discontinuation, avolition, shame and social isolation (Wahl, 1999; Markowitz, 2001; Rüsch *et al*., 2005). These negative consequences of self-stigma worsen the course of the illness, and increase the risk of suicidal behavior and suicide (Pompili *et al*., 2003). Moreover, self-stigmatization undermines the person's ability to work toward his or her life goals, and is a major obstacle in the rehabilitation and recovery process (Ritsher & Phelan, 2004; Angell *et al*., 2005).

Alternatively, some persons with mental illness express righteous anger at stigmatization and discrimination, and develop behaviors to enhance self-empowerment. They seek to change the role of persons with mental illness in the mental health system by encouraging consumers to become participants in their treatment plans; by advocating for improvements in the quality of services; and by promoting more resource allocation and legislation for the mental health system (Rüsch et al., 2005). Still others are neither hurt nor driven by public stigma (Corrigan & Watson, 2002).

Unfortunately, feelings of shame, hiding and avoidance behaviors are common within the Israeli consumer community. Consumer advocacy organizations in Israel are rare, and within these organizations, there are few leaders willing to disclose themselves in the media or at a public event.

Families

Family members of persons with mental illness may have stereotypes and prejudices about mental illness (Green *et al*., 2003, Peterson *et al*., 2006). Moreover, they may experience an associative stigma mechanism whereby the family unit is considered an extension of the person with mental illness (Lefley, 1992; Phelan *et al*., 1998; Struch *et al*., in press). Another source of stigma and discrimination for the family is self-stigmatization (Green *et al*., 2003). Some family members feel responsible for their child's, parent's, sibling's or mate's mental illness, and often experience self-blame, guilt and shame (Phelan *et al*., 1998; Biegel & Schultz, 1999; Struch *et al*., in press). Hence, the impact of public and self-stigma may be as harmful for family members as for the person with the mental illness.

A recent study of families of persons with mental illness in Israel found that they are stigmatized and discriminated against by the healthcare providers in their paternalistic attitudes and accusations; by the public's misunderstanding and lack of empathy; and by confusion and fear among friends and neighbors. Family members report feeling embarrassed about their close relative with a mental illness, and half of them blame themselves for having a role in development of the illness (Struch *et al*., in press). As a consequence, families can become isolated, and withdraw from their social network. Parents, spouses and siblings report changes in their relationships with other members of their nuclear family (Struch *et al*., in press).

Barriers to rehabilitation of persons with mental illness justify the need for anti-stigma campaigns and for adoption of anti-stigma and inclusion programs in Israel. Strategies found to be effective for reducing stigma and discrimination are described in the following section.

STRATEGIES TO REDUCE STIGMA AND ITS CONSEQUENCES

While there is a substantial body of research that defines the extent and impact of stigma, there is little study of what works to diminish it. Nevertheless, there is both past experience and current research that indicate that stigma can be reduced (Morrison *et al*., 1980; Penn *et al*., 1999; Pinfold *et al*., 2005b).

Efforts to combat stigma have relied on research findings directed toward identifying effective strategies to fight stigma and discrimination, and to improve the social status of persons with mental illness (Holmes *et al*., 1999; Byrne, 2000; Pinfold *et al*., 2005b; Heijnders & Van Der Meij, 2006). An example of one unique national and institutional initiative is the successful anti-stigma campaign in New Zealand, called 'Like Minds Like Mine' (http://www.likeminds.govt.nz). In 1997, the Ministry of Health of New Zealand initiated this project to reduce the stigma and the discrimination experienced by persons with mental illness and to promote their social inclusion with funding for both nationwide and community-based programmes. 'Like Minds Like Mine' uses strategies such as an award-winning mass media campaign; contact strategies such as promoting active involvement of persons with experience of mental illness; community action in several locations around New Zealand by developing and implementing locally based education, training and grassroots activities aimed at attitude and behavior change; education and training workshops for police officers, mental health providers, Housing New Zealand and Ministry of Social Development; and implementation of a national discrimination survey recording people's experiences of discrimination in relation to their mental illness (Vaughan & Hansen, 2004; Peterson *et al*., 2006).

'Like Minds Like Mine' has been evaluated on multiple levels and has shown the capacity to change both attitudes and behaviors (Vaughan & Hansen, 2004).

Another example of a more specific effort to reduce stigma and promote community integration is a recent project that was delivered by consumers and a faculty member from the University of Medicine and Dentistry of New Jersey (UMDNJ), and combined three approaches to decreasing stigmatizing attitudes among an adolescent population. Those approaches were: (1) education about mental illness and recovery; (2) inclusion of consumers of mental health services in the development of content of the intervention and facilitation of those presentations and; (3) emphasis on sharing personal stories of recovery with the target audiences. The results of this study indicated that a

Table 1
Strategies to reduce public stigma and discrimination

Anti-stigma Strategies	Objectives
Education	Challenge inaccurate stereotypes about mental illness and replace them with factual information
Contact	Facilitate interpersonal contact between persons with mental illness and members of the target group
Protest	Frame the moral injustice of continued prejudice and discrimination; then instruct members of the target group to suppress the attitude
Consequences	Reward people for positive expectations and affirmative actions. Withhold rewards for stigmatizing attitudes and discriminatory behavior

Adopted from: Corrigan (2004).

one-hour informational session developed and facilitated by consumers can significantly affect the attitudes of adolescents toward persons with mental illnesses (Spagnolo *et al*., submitted).

The strategies that were found to be the most effective for reducing stigma and discrimination (Holmes *et al*., 1999; Corrigan *et al*., 2001; Corrigan & Gelb, 2006; Ritterfeld & Jin, 2006) are presented in Table 1. Some of the strategies address the negative attitude of a particular group, some address the negative behavior and some address both.

APPLYING WHAT HAS BEEN LEARNED TO THE UNIQUE SITUATION IN ISRAEL

Based on a review of strategies from anti-stigma programs in different countries, we propose to apply what has been learned elsewhere to the situation in Israel. In the next section, we discuss strategies to overcome barriers among specific power groups within Israeli society.

Hebrew terminology of mental illness

This involves applying the experience of other countries in the world (Hirosawa *et al*., 2004) in order to find a new term as an alternative for 'machalat nefesh'. The new term should consider the multidimensionality and complexity of the illnesses, and reflect research findings about the etiology and mechanism of mental illnesses. A recent example of trying to find a better name for schizophrenia, schizophrenia subtypes and anti-psychotic medications is an interesting proposal made by Levin (2006) (i.e. Neuro-Emotional Integration Disorder (NEID) replacing schizophrenia; motoric type replacing catatonic and Neuro-Emotional Integration Enhancing medication replacing anti-psychotic medication). The process of finding a new Hebrew term that will be more correct and less stigmatizing should be in collaboration with consumers, their families, researchers and clinicians.

Employers – workplace strategy

This strategy is to apply modifications and affirmative action as written in the Equal Rights for Persons with Disabilities Law (1998). Modifications include altering, equipment, job requirements, work hours, job hiring tests, training, communication of instructions for performing tasks, and work procedures. According to the law, affirmative action is 'any action designed to correct a prior or existing discrimination against persons with disabilities or designed to advance the equality of persons with disabilities' (Equal Rights for People with Disabilities Law, 1998). In parallel with enforcement of this law, interventions to reduce stigma and enhance work inclusion should be implemented. Planned and facilitated social interactions among persons with mental illness, employers and co-workers may help reduce fear and misconceptions about persons with mental illness. For example, extending the Israeli project 'structural dialogue' (Shor & Sykes, 2002) in which persons with mental illness are telling their personal stories in a workplace setting may help employers and/or co-workers to relate to them with less stigmatizing and more accepting behaviors. Such interactions can create opportunities for becoming familiar with persons with mental illness and life experiences; enabling employers and co-workers to discover the humanity and diversity of persons with mental illness; and, in turn, persons that lead the structural dialog may be positively affected by being seen and related to in ways that validate their worth (Shor & Sykes, 2002). Moreover, facilitated interactions can provide opportunities to discuss consumers' life experiences

and consequently increase empathy, reduce fears, and counter stereotypes. Establishing good communication early can help resolve issues, and prevent future misunderstanding and problems in the workplace. The combination of accommodations and affirmative actions derived from the Israeli Equal Rights for Persons with Disabilities Law and anti-stigma interventions may enable more Israelis with mental illness to enter and stay in the workplace, and to earn a living wage.

Landlords – housing strategy

This strategy is to implement anti-stigma interventions to encourage contact between persons with mental illness and neighborhood residents, and to educate residents about mental illness, rehabilitation and recovery. Contact and educational interventions may reduce fears of neighborhood residents and forestall objections to housing for persons with mental illness. Israeli Community Centers ('Matnasim') are ideal locations for these interventions, which could be integrated into 'Amitim' (which means friends), an existing program that conducts outreach to bring persons with mental illness into the centers' standard recreational, social, and cultural activities. Community-based housing can enhance cohesion among residents by having evening activities for the public with lectures, movies, shows, plays and art shows, thereby giving residents more opportunities to interact and share cultural and social experiences.

At the core of housing problems, however, is the unmet need for Israeli fair housing legislation similar to protections from work discrimination under the Equal Rights for Persons with Disabilities Law, 1998. Until fair housing legislation is adopted, community- and neighborhood-level interventions are the only recourse to combat discrimination against persons with mental illness. If such legislation is enacted, then these same interventions will be adjunct activities to help build stable neighborhoods for consumers who want and need housing, and for community members who want to feel that their quality of life and security are not threatened.

Criminal justice professionals – training strategy

This strategy involves using methods to prevent false arrests and unnecessary use of force against persons who display psychiatric symptoms, and to facilitate their witness report and/or testimony. Police officers' first contact with patients may be in potentially dangerous or threatening situations where, because of their mental illness, consumers may show exaggerated symptoms of their illness or display signs of acute stress. Officers should be aware of symptoms of the illness. Without training in mental illness, its manifestations, and behavioral management in these situations, the police may interpret patients' behaviors as not just bizarre, but suspicious or dangerous. However, with training, the police can more accurately differentiate criminal from illness behavior, and, if necessary, can refer the person to the mental health system rather than the criminal justice system. In cases where a person with mental illness is the victim of or the witness to a crime, reasonable accommodations can take into account his or her special needs during the witness report and testimony process.

Policy-makers and politicians – accountability and consequences strategy

This strategy involves using political power to influence decision-makers about the need to change negative attitudes and discriminatory behaviors toward person with mental illness, and to instead encourage positive attitudes and behaviors by adopting policies that favor consumers' empowerment and recovery. For example, the growing power of the Israeli coalition of consumers and family organizations may encourage Israeli policy-makers to allocate more resources to community-based services which promote self-empowerment and recovery – instead of allocating most of the

resources to the psychiatric hospitals, and other forms of institutions, that preserve the social exclusion of persons with mental illness. Consumers and family advocates can send powerful messages that stereotyping, stigmatizing and discriminatory behaviors have no place in an enlightened, educated society. Policy-makers and politicians are public representatives, and most need to be elected. The Consequences Strategy (see Table 1) gives examples of ways that consumer and family groups and organizations can influence policies to be favorable to the mental health field. Moreover, educate and initiate meetings, conferences and special events that will present the skills and qualities of persons with mental illness with their specific challenges may also influence the decision-making of policy-makers and politicians about the field of mental health.

Healthcare providers – education strategy

This strategy aims to engender a paradigm shift to change paternalistic behaviors and coercive treatments to recovery-oriented practices that encourage consumers' employment, independent living and relationships in the community. A recovery approach that includes education and contact might enable providers to stop viewing consumers as childlike, and instead see their potential for independent functioning in social and work roles. Mental health providers, both in psychiatric hospitals and community-based rehabilitation services that are driven from the Israeli Rehabilitation Law (2000), should be encouraged to deliver recovery-based interventions and diminish attitudes and behaviors that decrease hope and self-empowerment. Changes in healthcare policy to reimburse recovery approaches, and life skills training, could put financial pressure on providers to change behaviors.

The media – education strategy

This strategy aims to use information and pressure to convince the media to launch campaigns that increase information and awareness about mental illness and show the persons behind the illness. The media represent society's cultural norms, and can be instrumental in changing culture. Mental health advocacy organizations (i.e. the Israeli coalition of consumer and family organizations) should provide the media with information on mental illness, injustices suffered by consumers, insufficient allocation of funds to the mental health field, personal stories about being stigmatized, and spotlights on successful recovery and rehabilitation programs. Moreover, providing training programs for consumers in order to develop their skills and confidence in effective communication through the mass media is extremely important. For example, based on the model proposed by Kutner & Beresin (1999) Israeli advocacy and consumer groups can implement a 'media training' that includes: providing the context to understanding how reporters, talk-show hosts, call-in radio hosts, and program producers think, while emphasizing the different and sometimes competing motivations of the people involved in reporting a news story or creating an information/entertainment program; teaching the consumers how to structure their responses to questions asked by the interviewer; and simulation interviews that will allow the consumers to practice their 'media skills' in various media domains. These actions may balance the Israeli media coverage of mental health issues and create a positive public atmosphere concerning mental illness and utilization of mental health services.

Persons with mental illness – educational strategy for self-empowerment and political activism

Use self-empowerment interventions to reduce self-stigma. Fostering self-empowerment is of great importance for improving quality of life, promoting recovery, and facilitating integration of

persons with mental illness into the community, workplace and society. Empowerment has three main elements: self-esteem/self-efficacy, actual power, and community activism (Rogers *et al*., 1997). Empowerment is 'having decision-making power, access to information and resources, and a range of options from which to choose; using assertiveness; having hope for the future; unlearning conditioning; learning how to express anger; affecting change in one's life and the community; learning important skills; improving one's self-image; and overcoming stigma' (Chamberlin, 1997). All rehabilitation providers in Israel, whether if they work in hostels, half-way houses, rehabilitation units in psychiatric hospitals or in the headquarters of the Ministry of Health, should include interventions and activities that enhance consumers' self-empowerment and reduce self-stigma. Diminishing self-stigma and fostering self-empowerment activities should enable consumers to develop positive attitudes and beliefs about their abilities to assume societal roles. A life skills approach should teach consumers to articulate goals for developing a social support network, living in stable housing, working in a challenging job, contributing to the community, and having limited or no impairment in functioning (Spaniol, 1999).

Families – applying interventions that address mental health stigma within and toward families of persons with mental illness

Family members have an important role in the rehabilitation process and recovery, and should be included in mental health services. There are several strategies that family members and mental health professionals can use to tackle the public about stigma and to improve families' and consumers' quality of life (Struch *et al*., in press). Support centers for family members that have been recently founded by Ministry of Health and non-profit organizations can prepare a psychosocial education kit or seminar for family members in order to provide information about the etiology of the illness, the course of the illness, rehabilitation, and recovery. Local support and social groups can encourage families to develop a new network with similarly affected families. Taking part in family groups may provide mutual support, assist in developing coping skills, reduce feelings of shame, and help to enhance self- and family empowerment. 'Parents for parents' peer education pairs experienced and high-functioning parents with parents in their early stages of coping and adjusting to a child with mental illness. The first coping stage is characterized by feelings of confusion, fears, hopelessness, denial, embarrassment and shame. Helping parents through this first stage prepares them with coping skills to enhance their and their child's functioning. Support groups for siblings will help these children feel less lonely, as if they are the only children they know who have a sibling with a mental disability. Potential problems that affect siblings should be addressed, such as acting out in order to get attention, feeling that they have to do extra, either at home or school, to prove that they and the family are 'normal', feelings that they are somehow responsible for the mental illness and similar childhood adjustments to a chronic health condition. Finally, family dynamics and relationships should not be neglected.

SUMMARY AND CONCLUSIONS

Mental illness stigma and discrimination are worldwide phenomena that influence the rehabilitation and recovery process as well as social inclusion of persons with mental illness. Nowadays, when most mental health treatment and rehabilitation is community based, it is very important to include the community in the rehabilitation process of persons with mental illness by delivering anti-stigma

or pro-inclusion interventions. Addressing the negative attitude, prejudice and discrimination of the groups that have the power to allow or prevent life opportunities of persons with mental illness (i.e. employers, landlords, media and healthcare providers), and enhancing their familiarity and knowledge about mental health field, may remove the social barriers. In this article we refer to each power group by presenting its unique interaction with persons with mental illness while proposing ways to reduce negative attitudes and behaviors. We believe that evaluating the effectiveness of the proposed strategies in Israel and implementing them as part of the policy of community-based rehabilitation services may improve rehabilitation, recovery and social inclusion of persons with mental illness and may, in turn, improve the society as a whole.

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