

The mental health consumer movement and peer providers in Israel

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Self-help peer-support groups in Israel emerged in the 1980s and, over time, dynamically interacted and co-developed with the statutory mental health (MH) system. In this editorial, I outline historical milestones of how the evolution of the Israeli mental health system was influenced by the consumer movement. A brief depiction of the consumer movement history. At first, consumers operated outside of the mainstream MH system. Gradually, consumer groups and institutional personnel joined efforts towards community integration and enhancement of quality of life, pushing forward a person-centered recovery orientation. In turn, some administrators and key stakeholders in rehabilitation community services grew to value the impact of knowledge-by-experience in contemporary mental health care. In this context, over the past decade, peer roles were developed in the mental health system, including consumer-providers in community services and peer specialists in inpatient psychiatric hospitals. The insertion of peer roles into the mainstream MH system is far-reaching, including the placement of a peer-project coordinator within the ministry of health. I describe the unique contribution of peers, as experts-by-experience, to mainstream professional knowledge and practice. I also highlight the potential challenges involved when peer models of care are added to traditional medical models of care. The Israeli case demonstrates how the consumer movement can play an active role in MH systems and be acknowledged and recognised as a partner for changing policy, practice and reshaping formal institutions. In addition, they play a vital role in the development of peer-support services.

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The consumer movement and peer-support roles developed in parallel to the historical maturation of the Israeli mental health system. The consumer movement is based on the premise that personal subjective experience provides valuable knowledge which is important for policies and practices in mental health. The impact of the consumer movement on mainstream institutions can perhaps be appreciated through the permeation of the term *Mitmoded* (in Hebrew) – meaning a *coper* (Rofe, 1998; Oren, 2007) as a substitute for the term *mentally ill* (in Hebrew *mentally ill* translates to ‘sickness of the soul’) commonly used to address individuals with psychiatric disorders and disabilities. *Mitmoded* is by now a familiar term to most MH practitioners and administrators.

The use of this wording connotes a recovery-oriented/person-first approach, paralleling similar recovery approaches in other countries. It represents a proactive state towards one’s life in the aftermath of mental illness and a commitment on behalf of professionals to support individuals in their recovery

processes and their striving for personal life goals (Anthony, 1993; Leamy *et al.* 2011).

In this editorial, I briefly describe the historical evolution of the MH system in Israel and the role that consumer movement and family members played in it. I then describe two key peer-support roles developed over the past decade and highlight their potentiality and pitfalls. Noteworthy, there is a lack of documentation of the consumer movement and peer support. Thus, this editorial is based on having accumulated informal, internal and media documentations, papers of opinion, interviews with stakeholders and involves the sole interpretation of the author. I use the terminology consumers and service users interchangeably throughout this text, which are the Hebrew terms most commonly used in Israel.

Until the 1980s: institutional period and the medical model

In the first few decades after the establishment of the State of Israel in 1948, government efforts focused on supporting individuals in acute states of mental illnesses, such as florid psychoses and major depressive episodes. The Ministry of Health invested resources to

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enlarge the number of psychiatric beds and establish psychiatric hospital services (Aviram, 1996; Levy, 2010). This period of time is characterised by an institutionalising orientation and dominance of a medical model.

Around 1980, consumer-led and self-help activities begin to form in response to frustrations from the mental health system (Lachman, 1998). Consumers and family members formed autonomous self-help groups and organisations independent of policy makers and professionals. Among the first such groups was Malam ('mitmodedim lema'an mitmodedim', i.e. copers for copers) (Rofe, 1998). Perhaps the most pressing needs of these organised activities were to share and voice their common experiences and grievances. The motivation was to shift from a passive sense of helplessness to an active mode, operating for the sake of oneself or for other mental health service users (Rofe, 1998).

Until the 1990s: deinstitutionalisation, structural reform and changes in legislation

Over the next decade and up to the 1990s, economic conditions improved and, similar to policies in other Western countries (although lagging behind them), Israeli MH policy veered to deinstitutionalisation and more attention was put on developing outpatient services (Aviram, 1996).

This decade also witnessed legislative milestones involving the rights of patients and individuals with disabilities. The first milestone was the enactment of the mental patient rights law which grounded the rights of mental patients with regard to psychiatric treatment and hospitalisation. Further legislation involved the equal rights law for individuals with disabilities, to promote equality, prevent discrimination and support the integration of individuals with disabilities in society (ERD, 1998). A council comprised and headed by individuals with disabilities was formed to monitor and advise on the implementation of this law, indicating the increasing acknowledgement of service users' views.

Importantly, in 1994, a major reform was enacted through legislation for health insurance to all citizens and residents. This law ensures that all residents have basic health-care insurance. However the law *excluded* mental health services which lingered behind, under the responsibility of the Ministry of Health, with fewer economic resources and services, and were segregated from the general health care. In this decade, consumers from multiple forums and organisations have become active in advocacy for systems change. Notably, enduring pressures by Ozma – the national

forum of family members of mentally disabled – helped to promote legislation for mental health (Ozma, n.d.).

Until 2000: rehabilitation reform

The gap between health and mental-health legislation drove the consumer and family members' movements to act together with professionals and administrators to make a change. In 2001, the enduring commitment of Israeli parliament member Tamar Goz'ansky together with pressure from family members and users of services, legislators, administrators and MH professionals, contributed to the enactment of the Rehabilitation for the Mentally Disabled law (RMD, 2001; Aviram, 2010). The RMD law is an important component in the long overdue MH reform. It provides a package of rehabilitation services and programs including housing, employment, adult education, social and leisure time activity, assistance to families, dental care and case management. Levels of hospitalisation have dropped significantly since its enactment, pushing forward the country's efforts to treatment and care within the community (Shershevsky, 2006; Aviram *et al.* 2007; Aviram, 2010).

Under the RMD law, a national council was established which monitors the implementation of the law and advises the government on how to further develop rehabilitation services for the mentally disabled. A major focus was the development of residential and occupational services in the community. The council includes individuals with mental disabilities as well as family members, some of whom served as its directors.

In addition to these major policy influences, the personal experiences of professionals with a lived experience of mental illness begin to be heard. These individuals share their concerns with the MH system and address problems of stigma and suicidality (Katzanelson-Bank, 1995; Rofe, 1998; Harris, 2012).

From 2000 to 2010: development of recovery-oriented care and enhanced involvement of consumers in shaping practices and policy

Around the turn of the century, joint initiatives of consumer activists and welfare/health institutions have developed. One such example is Benafshenu, an initiative that established information centers for service users and family members and conducted educational anti-stigma meetings in which consumers share their personal story with target audiences (practitioners,

families, administrators, youth, general public) to erode stigma and allow personal contact (Shor, 2008).

Moreover, under the establishment of the RMD law, additional consumer-voice projects evolve. One example is the consumer-surveyors project which trains consumers in conducting satisfaction surveys of residential and occupational services as part of their vocational rehabilitation. The consumer-surveyors cover numerous services serving thousands of mental health consumers. The survey outcomes have been used to provide feedback to service providers which help modify services in order to enhance their quality (Moran *et al.* 2017, 2018; Westman *et al.* in press).

In this period of time, the vision of recovery-oriented care (Anthony, 1993; Lachman, 2000; Oren, 2007) has been recognised in Israel by both policy and higher education. Recovery-oriented and person-centered interventions became a focus of attention, including the development of evidence-based practices known to effectively enhance consumers' quality of life (Farkas *et al.* 2005; Leamy *et al.* 2011). A range of interventions have been developed in Hebrew or adapted to Hebrew, including illness management and recovery, cognitive-dynamic interventions, self-advocacy, psychoeducational interventions, narrative enhancement therapy, readiness and family service centres (e.g., Hadas-Lidor & Lachman, 2007; Moran, 2011; Yamin *et al.* 2012; Shalev, 2017). These interventions and curricula integrate consumer perspectives and are taught at some universities, at the continuing-education school of rehabilitation and counseling centres across the country.

The recovery vision coincides with some of the consumer movement goals, emphasising a person-first approach and individually-tailored care. A dialogue between MH consumers, educators, professionals and students permeates these different courses through invited discussions with service users and guest speakers in classes. In addition, designated courses for mental health consumers were developed and run at the Hebrew University and University of Haifa, where consumers were encouraged to voice themselves and their perceptions about improving mental health services (e.g., Haf'el course). At least five courses of this sort were held which formed the infrastructure for graduates to later take active roles in shaping policy and practices. In parallel consumer and family member representatives were invited to take part in different forums that influence policy (i.e. governmental mental health committees, Israel's psychiatric rehabilitation association, the mental health reform committee). During these years a group of consumer activists also formed the consumer-provider training program (Oren, 2007) described below.

From 2010 to 2016: The finalization of MH reform legislation and embracement of peer positions in the government

Enduring pressure from consumer and family member organisations to finalise the mental health reform mounted during this period, through the press and the courts (Ozma, n.d.; Tzin, 2011). With other stakeholders, including parliament members, the reform was finally completed in 2015: a merger of mental health care with general health-care insurance. This reform ends the segregation between health and mental health sectors in the country. Currently, in a transitional phase, it is expected to provide higher-quality MH community services.

In these recent years, consumers (e.g., Tzin, 2011) and family members have regularly voiced their views and concerns through personal, professional and political platforms orally, in writing and through the electronic media (many examples appear in Lishma, n.d.; Malam, n.d.; Maman, n.d. and Ozma, n.d.). An increasing number of individuals with a lived experience of mental illness pursue higher education and research focusing on the study of personal experiences as consumers and professional providers (e.g., Goldberg *et al.* 2015; Bril-Barniv *et al.* 2016).

In addition, new alternatives to conventional treatment have been initiated in collaboration with consumers, such as the Soteria House – a peer-based alternative to hospitalisation in the vicinity of Jerusalem. Currently, consumers search for additional alternative models of mental health, exemplified by workshops at the Beer Sheva mental health center, where a group of consumers and professionals learn from initiatives such as the Finnish model of Open Dialogue and the Hearing Voices network model in the USA.

The consumer's voice is also increasingly embraced and integrated into the government. A position was opened for a peer-project initiator in the mental health rehabilitation division in the ministry of health. This position is filled by a consumer activist with a lived experience of mental illness. It provides an opportunity to develop peer-led projects, such as the peer-specialist project described in the next section.

Peer services in Israel: consumer-providers and peer specialists

Israel now has several opportunities for training of consumers in different roles based on experience-based-knowledge, supported by the ministry of health (see NSMHRIR Hebrew website: <https://www.ono.ac.il/schools2/health/national-school-for-mental-health-rehabilitation>). In these roles, the credibility of the

peer-supporter derives from their personal knowledge on recovery processes and their sense of camaraderie and empathy towards others in similar conditions. I will focus on two major roles for peer supporters within the mental health system: consumer-providers in community services and peer specialists in psychiatric wards.

The consumer-provider program

A consumer-provider training was designed and initiated by a small group of consumer-activists with the mission to turn one's personal knowledge on recovery into a rehabilitation expertise which can be provided to mental health service users (Oren, 2007). Over time, it became the largest formal peer-service organisation, integrating consumers as providers into mental health rehabilitation services across Israel.

The consumer-provider training is funded by the Ministry of Health and takes place in the national school of mental health rehabilitation and recovery (see NSMHRIR website) in Kiryat Ono. Training includes 20 weekly full-day study workshops for a group of mental health consumers. Topics, tasks and assignments relate to mental health rehabilitation systems, stigma, self-disclosure and recovery. Topic presentations are followed by group process facilitated by a consumer and a MH practitioner. Following the successful completion of the course, consumers can be employed in different mental health residential and occupational community services. In addition, if interested, they are eligible to receive ongoing supervision through Yozma-Derech Halev, a consumer-provider supervision program (Merzer-Sapir *et al.* 2009; Cohen, 2011).

Hundreds of consumer-providers have been trained and employed in different geographical areas around the country, many of which receive ongoing supervision (A. Gefen, personal communication, 2017). Consumer-providers often provide personal support, mentorship and tangible help to service recipients. Results from a recent survey found that consumer-providers support and serve as role models for service recipients; directors of services acknowledged the unique added value that consumer-providers bring to their MH services (Katz *et al.* 2013).

The motivations that drive consumers to be employed as providers involve, for many peers, a sense of personal mission to give back or change the system, as well as motivations for personal development and regaining work status (Singer, 2010). In this role, self-disclosure and identity are a recurring topic of discussion. The decision of when and what to self-disclose is often impacted by self-stigma and public-stigma as peers interface with different service contexts (Singer, 2010; Katz *et al.* 2013).

The peer-specialist program

The peer-specialist project (named Amitim Mumhim in Hebrew) was developed in collaboration with consumer-led groups with the National Social Security Institute (Bituch L'eumi) under the peer-project initiator at the Ministry of Health. This initiative extends peer-support roles to treatment settings. The project was launched in 2015, with a group of 15 peer providers who were trained and placed in two psychiatric hospital sites in the South and in the North of Israel.

Peer specialists work in different open and closed wards of the hospitals and perform multiple tasks. For example, they spend unstructured time conversing and contacting patients on the wards; hold personal meetings, facilitate groups on specific topics (e.g., illness management and recovery intervention/expressive arts), and participate in family consultations. Peer specialists are integrated with the staff, participate in staff meetings, consultations and rehabilitation committees. They are involved in decision-making processes about the allocation of rehabilitation resources to consumers after discharge.

While this pilot project is still in process, emerging qualitative data show that peer specialists can benefit patients in these hospital settings. Interviews with staff show that daily contact between staff and peer specialist created new opportunities for communication that enriched their understanding of the complexity of mental health conditions and appreciation of the struggles in recovery (Chezkner, 2016). For example, in some instances, peer specialists brought to the table the consumer's voice, impacting decision-making processes regarding the allocation of services such as housing, vocational and health services after discharge (RMD, 2001; Chezkner, 2016). More systematic and comprehensive data are expected from this project in the future.

Challenges to peer work in MH

With the growing integration of consumers in MH services, new challenges emerge. One of the challenges involves the peer-worker identity. The interface with MH services raises questions and confusion regarding the occupational identity and clarity about their role in various services and settings. Important issues for consumer providers and peer specialists include their unique competencies and disclosure (with whom, timeliness, appropriateness, etc.). Such questions impact the training of peers and lead to ongoing examination and development of its conceptualisation (Goldberg *et al.* 2015; Legere & Farkas, 2016; Bendas-Jacob, 2017; NSMHRIR, 2017 course for consumers-as-providers Website (Hebrew)).

In addition, situational/environmental conditions may vary across settings and influence the optimal expression of peer providers in their peer roles. For example, while rehabilitation services in the community have been exposed to the consumer movement for a relatively long time, treatment settings tend to be less aware and less open to the notion of MH peer providers. Psychiatric hospitals/facilities have historically had little contact with the consumer movement, and thus may be less prepared for the assimilation of peer roles and their consumer perspective. This is understandable, given the inherent contradictions between peer models and traditional medical model that is salient in MH structures. The peer role – in its purest form, is a contributor of knowledge-by-experience to the professional scholastic body of knowledge (Borkman, 1976, 1990). Naturally, there is a risk of dilution of the peer role's distinct potential due to its vulnerable position prone to 'co-optation' – a 'state of tension between formal authority and social power' (Selznick, 1948, p. 35, see also Thompson & Coskuner-Balli, 2007; Baur & Schmitz, 2012).

Some strategies that help strengthen peer roles include continued peer-training/supervision, maintaining connection with consumer-activist organisations and developing a clear notion of what it means to be and act as a peer provider in these settings (Moran, 2011; Moran *et al.* 2012, 2013).

Finally, beyond questions of job definition, there is also the issue of effectiveness. While much development of peer roles has been conducted in the Israeli mental health services, so far there has been lack of study of the end results of peer roles. There is need to systematically examine what recipients of peer services have to say about peer-support services and what are the outcomes of these newly developed roles (Lachman *et al.* 2017).

Summary and conclusion

Consumer-led self-help and peer-support activities emerged in Israel during the 1980s stemming from a sense of frustration with MH services and a need for solidarity. Self-help/peer support and activist groups formed, broke and reunited, pushing agendas to enhance services and fight stigma in MH care (e.g., see Rofo, 1998; Perry, 2000; Alperovitz, 2002; Singer, 2010). Over time, consumer activists developed collaborations with MH administration with the joint goal of enhancing the quality of services, human rights and person-centredness.

Overall, the consumer movement plays a vital role as a partner in shaping policy and services. The implementation of peer roles has brought the consumer perspective into traditional mental health and has provided service recipients with knowledge by

experience to complement clinical and academic knowledge. Continued involvement of consumers in the shaping of peer services is vital for its future success. In addition, further developing peer occupational tracks, through training and supervision, increasing fidelity of peer-support roles and monitoring of outcomes are important.

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