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When social work students meet workers with mental-health lived-experience: a case study

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\textbf{ABSTRACT}

Mental Health Workers with Lived Experience of mental illness (MHWLE) are a growing workforce in countries veering to recovery orientation in mental health services. MHWLE entrance into the workforce challenges conventional role-definitions and practices in mental health services. This case study portrays issues raised by social work students following a workshop with MHWLE as part of their graduate-level training. A workshop with MHWLE was designed for 24 social work graduate students during a mental health seminar. Following the workshop, a focus group was held. The students’ thoughts and experiences during the workshop were collected and analyzed. Thematic analysis of the topics raised by the students included three main categories: (i) Experience of confusion about MHWLE role, (ii) Controversies regarding MHWLE disclosure of lived experience, and (iii) Concerns about boundary setting by MHWLE. Connecting MHWLE with social work students in academic settings can help better prepare social workers for the encounter with peer services in the mental health field, and support harmonization of this new yet rapidly growing workforce in mental health. In addition, the students had an opportunity to self-reflect and explore their own views and experiences regarding fundamental aspects of professional identity and their own practices in general.

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Peer support workers; consumer-providers; social work training; mental health service and education

\textbf{Introduction}

In the last couple of decades, there has been a rapid growth in the number of people with lived mental health experience who work as service providers in the mental health field (Davidson, Bellamy, Guy, & Miller, 2012; Gillard et al., 2017; Repper & Carter, 2011). They are increasingly recognized as carrying merit to various stakeholders in the field of mental health (service recipients, staff, family members, etc.), mainly by being role models and living evidence that recovery is possible, and the sharing of their own experience in an eye-level-camaraderie approach (Mead & MacNeil, 2006).

A plethora of terms have developed trying to capture and describe the versatility of activities performed by these people in different services such as peer specialists, consumer-providers, recovery mentors, peer supporters, etc. (see: Stamou, 2014). Here we choose to use a generalized term ‘Mental Health Workers with Lived
Experience of mental illness’ (MHWLE). In using this term we attempt to address all individuals with a lived mental health experience who work in various roles in mental health services.

MHWLE work in ‘conventional roles’ or ‘specialist roles’. Conventional roles can be held by people without lived experience (case managers, rehabilitation mentors, etc.) (Chinman et al., 2014, p. 431). Specialist roles are roles that are based on disclosing peer status and using lived experience as the main tool as providers (Moran, 2017).

Studies on MHWLE in specialist roles have found that they benefit service users through empowerment, a sense of empathy and acceptance (Repper & Carter, 2011), as well as enhancing the recovery, esteem and workability of the MHWLE themselves (Miyamoto & Sono, 2012; Moran, Russinova, Gidugu, Yim, & Sprague, 2012). In addition, a significant contribution for staff was reported in services where MHWLE are open about having a personal mental health experience. Staff highlighted the benefits of exposure to knowledge based on personal experience, such as opportunities for staff to reassess their attitudes and perceptions, as well as to broaden considerations regarding rehabilitation and treatment interventions that are user-perspective based and person-centered (Chinman et al., 2008; Doherty, Craig, Attafu, Boocock, & Jamieson-Craig, 2004; Pollitt et al., 2012).

While the introduction of MHWLE brings added benefit to services, it also involves challenges across multiple levels (i.e. for service recipients, MHWLE themselves, staff members, service and policy, see: Miyamoto & Sono, 2012; Moran, Russinova, Gidugu, & Gagne, 2013). One major challenge involves stigmatic attitudes of staff expressed in pessimistic views that due to the mental state of MHWLE they will not be able to withstand the requirements and pressures of working in mental health (Gates & Akabas, 2007).

In addition, the integration of MHWLE destabilizes the dichotomous separation between ‘healthy-therapist’ and ‘sick-patient’, eliciting a sense of threat among staff that don’t have lived mental health experience (Carlson, Rapp, & McDiarmid, 2001). Finally, a number of studies report ‘role confusion’ among staff members regarding the way they ought to address MHWLE—as service users or as colleagues (Carlson et al., 2001; Gates & Akabas, 2007; Moran et al., 2013).

**MHWLE in the Israeli context**

In the first 50 years of the State of Israel, the mental health system was hospital-based with only limited ambulatory services in the community. In the year 2000 a mental disability act—Rehabilitation in the community of persons with Mental Disabilities (RMD, 2001)—was implemented signifying a turn of the times. Thus, the system moved towards community-based care with a more individualized orientation, and efforts were invested in developing community rehabilitation services (Moran, Baruch, Azaiza, & Lachman, 2016). The RMD provides eligibility for an array of services to individuals who have more than a 40% disability rate (as determined by a psychiatrist). These include varying degrees of support in different domains such as residency, occupational, leisure, social services, etc. (Hornik-Lurie, Zilber, & Lerner, 2012). The workforce assigned through the RMD law consists of professionals such as social workers, OTs,
psychologists, psychiatrists, etc., and paraprofessionals with no formal professional training.

Paraprofessionals comprise the majority of the workforce and usually meet service users more frequently than professionals. They assist service users in a wide range of daily activities determined by the service (residential, occupational, etc.) they work for. For example, a paraprofessional in a residential service will work with the service users on ADL skills, cooking skills, etc. (Moran, Westman, Weissberg, & Melamed, 2017). Professionals often employ case management, develop rehabilitation plans, communicate with the Ministry of Health (e.g., reports), supervise paraprofessionals, etc. (Ministry of Health, 2009).

In 2005 a course was opened inviting persons with lived experience of mental illnesses to train as MHWLE and later join the workforce. The course was then developed into a program named ‘consumers as providers’ to continue providing support to MHWLE (Merzer-Sapir, Harlev, & Mautner, 2009). Over the years, the program has provided support services to thousands of MHWLE, and today the program provides services to approx. 300 MHWLE. The majority of MHWLE work in paraprofessional roles (where they often receive supervision from social workers), yet there is a growing tendency to pursue professional career tracks as social workers, etc. (see: Goldberg, Hadas-Lidor, & Karnieli-Miller, 2015).

Disclosure and utilization of one’s lived experience varies among MHWLE in the Israeli mental health workforce. Most MHWLE engage in conventional roles. In these roles, they can choose whether or not to disclose having a psychiatric diagnosis and the extent of using their lived experience as service providers (Moran, 2018; Moran, Russinova, Yim, & Sprague, 2014a; Singer, 2010). In 2015, 10 peer specialists started working in two psychiatric hospitals involving overt disclosure and extensive use of their own lived experience (Hornicl-Lurie et al., 2018). While specialist roles are in their initial stage of development in Israel, they are rapidly gaining momentum.

Thus, MHWLE are becoming a more and more integral part of the Israeli mental health system. As a result, a greater number of social workers are expected to encounter MHWLE in the field. In spite of the growing numbers of MHWLE, academic training of social workers barely addresses the expected implications regarding the interface with MHWLE in the field. In fact, the majority of social workers encounter MHWLE only after they have completed their studies and formal training.

The current study describes a workshop in which graduate level social work students met MHWLE in an academic setting. It portrays a focus group discussion between the students following the workshop with MHWLE. The aim was to examine the processes experienced and to identify issues and dilemmas elicited following this encounter.

**Methods**

**Context of study**

In 2016 a representative of the ‘consumer as provider’ program (1st author) and the head of a mental health track (2nd author) from the social work department at an academic institution, joined together to collaborate with the aim of exposing graduate level social work students to MHWLE. The workshop was conducted as part of a mental
health practicum course (i.e. field seminar) whose main goal is the integration of theory and practice (Giddings & Vodde, 2003).

Participants were 24 female students, with varying levels of familiarity with the field of mental health: some were already working in mental health services since having completed their BA in social work. Others were studying in a retraining program track, with little experience with mental health services and total lack of exposure to MHWLE.

The meeting with the MHWLE was held after the field seminar had hosted additional guests from the mental health field: a lecture and discussion by a head psychiatrist of an eating disorder psychiatric unit, and a co-consultation with a mental health consumer employing ‘behind a mirror’ technique followed by direct conversation with the mental health consumer. In both these meetings, the students were highly engaged and interested, they asked questions and offered their thoughts and feelings regarding topics raised and related mental health issues. A vivid conversation and positive atmosphere characterized these classes.

In the following MHWLE workshop, two MHWLE presented their recovery story and described the roles and activities they conduct as MHWLE. One MHWLE works as a rehabilitation mentor in a group-home (paraprofessional role), while the other is a social worker who provides support and supervision to other MHWLE. Following each of the MHWLEs’ self-presentations, time was given for questions and answers. Notably, unlike the conversations with the previous practicum-guests, the discussion following the MHWLEs’ presentation was markedly different: the students were silent, only a few questions were asked, and it seemed difficult to develop a discussion. The sharp contrast between the students’ interaction and responses to the first two guests as opposed to the MHWLE, made the second author aware of topics that are sensitive and unprocessed with regards to MHWLE amongst the students. In the following week, she (2nd author) opened up the topic in a guided discussion (i.e. focus group) technique, to try and better understand the experiences, thoughts and feelings of the students, and why it was so hard to get a conversation going. This time the students expressed themselves freely and fluently, raising many issues that had concerned them during the workshop.

**Methodology and procedure**

The authors used a case study design based on data collected from a single focus group. Baxter and Jack (2008) claim that it is important for researchers using a case study design to define what is the ‘case’ being presented and analyzed. In this article, the case is not the participation of MHWLE in the workshop but rather the report of the focus group discussion between the social work students about their experiences in the workshop. Additional variables such as the encounters with previous seminar guests and the heterogenic levels of field experience among the students serve as important context to the case in hand (see: Yin, 2003).

A focus group discussion was instructed and led by the second author, addressing the students’ experiences, feelings and insights arising in response to the encounter with the MHWLE (Gibbs, 1997). One student wrote a word-by-word protocol noting the verbal transactions during the discussion. Confidentiality and anonymity were ensured.
by erasing any identifying names of individuals and services mentioned by the group members. The students gave their written consent to use the contents of the discussion.

**Data analysis**

Initial thematic analysis was conducted by the student who wrote the protocol. She is a practicing social worker and director of a residential service. She has experience in employing and supervising MHWLE. The student and the second author reviewed this analysis and constructed an initial thematic structure. Next, following a series of meetings and discussions between the first and second authors about discrepancies and points of ambivalence in the initial thematic structure, the final thematic structure was developed. This process was guided by the five stages of thematic analysis recommended by Rabiee (2004) including:

(i) Familiarization with the data—both authors engaged in thorough reading of the focus group protocol, as well as discussions with the student who took the protocol and had her own professional perspective.

(ii) Identifying a thematic framework—based on the comprehensive reading of the protocol and the initial thematic structure, the authors identified and developed the final thematic structure as presented in this article.

(iii) Indexing the data according to the thematic framework—after a thematic structure had been established, the authors returned to the protocol and indexed each quote according to its matching theme.

(iv) Charting—the quotes were 'lifted' from their original context and arranged in a separate worksheet with other quotes belonging to the same theme.

(v) Interpretation of themes while considering context—the authors analyzed each theme separately and identified its main subjects and narrative, while taking into consideration the general context and narrative development within the group.

**Results**

The themes that were identified involved immediate experiences and attitudes of the students following the encounter with MHWLE. These experiences and attitudes elicited insight and discussion about professional identity and social work practice in general. Three main themes emerged: (i) The first theme involved an experience of role confusion and awkwardness with which the social work students greeted and approached the MHWLE during the meeting. (ii) The second theme involved issues of self-disclosure and sharing by MHWLE in their work-role, specifically in cases where social workers supervise MHWLE. (iii) The third theme involved concerns about boundary crossing in MHWLE work.

1. Experiences of role confusion

The majority of the students noted the silence in the class that followed the MHWLE presentation and that they felt too awkward and confused to respond. One participant said: 'The dilemma of how I was supposed to look at them paralyzed me. I wasn't sure what the
objective was? As a professional how was I expected to react?'. Another participant commented on the students’ notion that the MHWLE focused mainly on their work and did not share much detail about their personal stories of coping with mental illness:

Were we looking for the pathology? We wanted the story, because this is how we work [i.e. what we are used to]. We lacked the professional view [i.e. the ability to see the MHWLE as colleagues], we didn’t manage to make this kind of shift.

The student mentions the habit of mental health professionals to view MHWLE from a pathological framework as an explanation for the difficulty of ‘making the shift’ and relating to them as service providers and colleagues. Another student summarizes this as ‘it is hard for us to contain this complexity’.

This confusion about the way MHWLE were to be perceived and addressed in class was salient in the students’ sharing their sense of a sharp contrast between the MHWLE workshop and the previous workshops with the psychiatrist and the mental health consumer. Specifically, this refers to the degree to which ‘therapeutic elements’ such as empathy and empowerment emerged from within the students in each of these encounters. With the psychiatrist, absence of therapeutic elements was evident: ‘When we met with the psychiatrist who came to lecture to us, I did not think that we needed to be empathic towards her’. A comparison of their experiences was further explored with the mental health consumer’s visit:

What I experienced in the [group] conversation with the MHWLE contrasts with the conversation we had with the mental health consumer. There [with the mental health consumer] was a lot of empowering talk [but] with the MHWLE there wasn’t anything I considered to be empowering. [Does that mean that] only when we put on the ‘therapist hat’ empowering utterances emerge from us?

The student claims that the role of ‘mental health consumer’ (i.e. patient) elicited a therapeutic approach (i.e. ‘empowering talk’) from the social work students, putting on the ‘hat’ of ‘therapist’ during the encounter itself. In contrast, the MHWLE’s role was unclear—on one hand a patient and on another a provider—and as such did not evoke a specific response. At this point of the focus group conversation, she invites the participants to explore the question—why they reacted so differently in the case of the MHWLE visit. A student responds to her call:

It makes sense we didn’t understand them [the MHWLE] in the same manner we understood the mental health consumer; they did not come as patients but rather as MHWLE. It is alright that we didn’t [attempt to emotionally] support them.

Another student said: ‘It is insulting to be over-empathic towards them’. And another one claimed: ‘There was actually something very equal in this meeting [with MHWLE]’.

The students’ discussion portrays first and foremost the confusion and struggle with the MHWLE not fitting into the dichotomous framework of being either a ‘provider’ or a ‘sick person’, and the behavioral implications of this confusion in their responses during the workshop. Interestingly, the conversation then veered to a discussion about deconstructing this dichotomy as an opportunity for a different approach—an equal, at eye-level encounter with MHWLE and the complex position they hold in the ‘provider-sick person’ continuum.
Some social work students emphasized the importance of continuous reflexive examination of feelings and thoughts when working with service users. They saw such a process as an integral part of their own professional development and also as relevant for MHWLE working in the field:

I left with a very heavy feeling from the meeting last week. All these years I have been working in the mental health field, I constantly self-reflect on what I do. We must ‘bring ourselves’ [i.e. self-reflect on the ways work ‘meets’ us personally]. [Yet] He [one of the MHWLE] talked about everything but his own coping with mental illness.

Another student said: ”[Because] we are the work tool, it is important that I am cognizant about my feelings towards the service user”. The students expressed an expectation for self-disclosure and sharing of personal processes by MHWLE, especially in professional supervision. One student provided an example of her own: ‘I have a [physical] illness in my family, and when I arrived at the hospital for my fieldwork I immediately shared this information’.

Others shared their own experience of failures when MHWLE have not brought their personal story into supervision. One student regretted that she lost a MHWLE who was under her supervision, when he decided to leave work because he was (wrongly!) accused of stealing:

When he left he said ‘this brings me back to bad places in my life, and that is why I quit’. I think that if I would have been aware of other aspects in his life history, we could have taken a different route.

That same student claimed that MHWLE, like any other mental health worker, should disclose and share personal experiences at least to their supervisors:

In our service [a supported housing service] all staff members receive supervision, where one can discuss with a supervisor what happens to you when encountering service users. When the MHWLE does not self-disclose [his mental health history] you cannot get to this kind of conversation, because the supervisor won’t always know about it.

In response, other voices were heard on this topic. A student described her impression from meeting the MHWLE who didn’t share much about his own illness as follows:

I looked at Daniel [pseudonym] and said ‘wow, a person that went through a crisis, no matter what it involved, can contribute so much to those he serves’. I wish I could have told him that. I think we can learn a lot from him. He has a lot he can give to his service users.

The students further discussed the personal choice of MHWLE whether to self-disclose or not and to what degree: ‘Who are we to determine [what’s right about disclosure]? You need to ask the person whether they want to. We cannot judge them, we haven’t been through what they have’.

Continuing this direction of thought, some recommended not to disclose:

I understand that it is subjective… Some people went through something 20 years ago and they aren’t interested in self-disclosing… I supervised a MHWLE [as part of her work in a supported housing agency] and I told her that it’s better that she doesn’t disclose to other staff members, so they will treat her according to the quality of her work and not according to what she’s been through as a mental health consumer.
Thus, the focus group processed and offered different viewpoints about MHWLE self-disclosure especially when under supervision of social workers. Some students felt that avoiding disclosure might be harmful to the quality of work and relationships with staff and service users. Others highlighted MHWLE unique contribution and choice despite varying levels of disclosure, implying the complexity of stigma and personal choice in the process.

(1) Boundary issues in MHWLE work

The topic of boundaries in MHWLE work was the third theme raised by the social work students. The main point of reference for the discussion was one of the MHWLE stories about how he often gives cigarettes (which he buys out of his own pocket) and provides coffee to the service user in the group-home where he is employed as a paraprofessional. He said that he does this out of empathy and identification with their lack of resources and his personal view that the group-home should feel like home, with minimal restrictions. Some of the social work students regarded this behavior as crossing boundaries and violating regulations regarding relationships between providers and service users. One student said:

There is a problem with the confusion, identification.. like when he said he gives cigarettes out of identification. It confuses the boundaries.

The student expressed the normative viewpoint of services whereby the provision of goods to service users can be perceived as malpractice, and in this case resulting from over-identification on behalf of the MHWLE. In response, another student interestingly challenged this assumption:

I wonder if it is our confusion [rather than the MHWLE’s confusion]—did he offer the coffee because he is a MHWLE, or because he is a human-being.. it can be a blessed thing, whether it happens because he has [personal] experience or if it comes from a human-to-human kind of thing.

Another student continued this line of thought and suggested to examine the MHWLE practice as an opportunity to re-examine current practice conventions: ‘You need to accept a challenging discourse [of the system] from MHWLE’. A third student who works in a supported housing agency further contextualized the discussion in a broader organizational framework:

There is a complex relationship between social workers and paraprofessionals even if we don’t take into account MHWLEs’ unique status. For social workers it is easier to set boundaries because of their work frame: [They] see the service user once a week [as opposed to] the paraprofessional who sees them more often than that and then it is hard to set a boundary. The issue of boundaries was always there [also with paraprofessionals who are not MHWLE].

Thus, some students did not perceive the coffee and cigarette practice as necessarily a violation of boundaries or a problem of over-identification by the MHWLE. The discussion broadened to view this behavior as a normative part of an approach that emphasizes a humane and less restrictive practice with service users.
Discussion

The current study presents responses and major issues raised by graduate-level social work students following a workshop with persons with lived experiences of mental illness who work in the mental health field (MHWLE). The first theme related to the students’ experience of role confusion when encountering the MHWLE, continuing onto a discussion about the place of disclosure by MHWLE in supervision, and ending with dilemmas about MHWLEs’ boundaries and practices with service users. The focus group themes extended to the social work students’ views and experiences of their professional identity and practices in mental health services. We found that this desired outcome was very much enabled by the mere presence of the MHWLE which in itself challenged conventions about the mental health worker role. Furthermore, the safe, educative environment of the seminar conducted outside of real-life mental health services facilitated this desired outcome.

At the heart, the students’ confusion about the MHWLE role reflects their difficulty to position themselves in relation to this role. Similar challenges of understanding MHWLEs’ roles and integrating them into mental health services have been documented (Carlson et al., 2001; Doherty et al., 2004; Gates & Akabas, 2007; Miyamoto & Sono, 2012). This confusion can be attributed to the dichotomous conventions of ‘healthy/therapist’ and ‘sick/patient’ as distinct polarized entities in the mental health field (Carlson et al., 2001; Doherty et al., 2004; Miyamoto & Sono, 2012). Such a dichotomy provided the students in the seminar the confidence and clarity with which they interacted and expressed themselves with the psychiatrists (‘healthy/therapist’) and with the mental health consumer (‘sick/patient’), including the choice whether to approach them with a therapeutic orientation during these two encounters.

In contrast, the unique status of MHWLE positioned between these two clear poles questions the validity of this perspective and therefore, undermines the assuredness with which the social work students behaved and felt during this encounter. They managed to acknowledge this sense of discomfort as related to the disruption of their dichotomous schemas, and then processed it through to a recognition of a more complex possibility—a therapist who is also a patient and vice-versa. Thus, the encounter with the MHWLE raised the students’ awareness and provided an opportunity to re-examine one’s own basic definitions and assumptions about the role of a (mental health) provider. In this sense, the confusion that the students experienced can be seen as a ‘positive confusion’ as it allowed them to reassess their professional attitudes and to explore (and perhaps adopt) broader, more complex and flexible perspectives.¹

Staff training and preparation for the integration of MHWLE have been advocated in previous studies, emphasizing the importance of enabling an open and honest dialogue regarding potential confusion, stigma and inner tension among staff members (Carlson et al., 2001; Chinman et al., 2008). The current study’s workshop with MHWLE conducted in an academic context allowed students to prepare for similar future encounters in the field. Thus, such a meeting in an academic setting, independent of one’s own workplace, offers a safe space for self-expression, and may provide an important learning opportunity for social work students (Unwin, Rooney, & Cole, 2018).
When considering the theme of disclosure and sharing of MHWLE in supervision, two different voices emerge amongst the students. The first voice is concerned (and even critical) of MHWLE who choose not to disclose and not to share relevant personal experience in supervision. They believe it harms the quality of services MHWLE give to service users and can even risk their employability. This voice stems from the students' own professional attitudes and experiences concerning the importance of disclosure and sharing in supervision. It is also strongly related to the role of social workers in the Israeli mental health system as supervisors of paraprofessionals, including many MHWLE. On the other hand, the second voice emphasizes the right for personal choice and varying levels of degree of disclosure and sharing by MHWLE. The students recognize that MHWLE can be effective in their unique contribution, even if they choose not to explicitly declare their mental health diagnosis.

Stigma and negative connotations towards people with mental illnesses make self-disclosure a complex issue (Bril-Barniv, Moran, Naaman, Roe & Karnieli-Miller, 2017), and even more so for MHWLE in particular (Gates & Akabas, 2007; Moran et al., 2014a; Singer, 2010). It is known that control over the process of disclosure is beneficial both to the person disclosing, and to those who they disclose to (Bril-Barniv et al., 2017; Moran et al., 2012).

In this context, it is interesting to see how the two polarized voices expressed by the students emphasize different approaches to MHWLEs’ choices and control over disclosure. The first voice highlights the position of MHWLE as mental health service providers who are expected to stand on par with the professional requirement for self-reflection and disclosure in supervision. The second voice highlights the MHWLE position as service users and thus gives preference to their choice and control over the extent of disclosure. While both voices are important, they see MHWLE as either ‘service providers’ or ‘service users’. Thus, they are essentially a reflection of the dichotomous perception we discussed regarding the first theme.

The third theme raises an issue which is highly relevant to social work practice in general—the question of boundaries in the mental health rehabilitation field (Finaret & Shor, 2006; Moran et al., 2014b; Williams & Swartz, 1998), and in particular relating to MHWLE work (Carlson et al., 2001; Doherty et al., 2004; Gates & Akabas, 2007). Here too, different voices are heard; first a ‘conventional’ voice emerged which is influenced by psychodynamic theories that stress the importance of settings and boundaries (Simon, 1992). Such an approach views boundaries as essential in order to develop a safe space so the patient’s needs and desires are well responded to. For some of the social work students, the offering of cigarettes by the MHWLE is perceived as a behavior which stems from the provider’s needs, and therefore a violation of boundaries. Another related concern is the natural closeness and shared experiences of MHWLE with service users that is seen as posing a risk of over-identification, whereby difficulties in maintaining boundaries may ensue. Similarly, in another study 9 out of 10 staff members expressed a concern about the ability of MHWLE to maintain proper professional boundaries with service users (Doherty et al., 2004; see also: Miyamoto & Sono, 2012).

On the other hand, the second voice emphasized the MHWLE work-role as a challenging practice which contributes to and has added value in the development of the mental health system as more humane and recovery-oriented. Such a contribution was described in studies that examine the integration of MHWLE (Chinman et al., 2008; Gates...
& Akbas, 2007; Hornick-Lurie et al., 2018) especially among mental health staff: ‘They [MHWLE] often see things that we might have blind spots on.’ (Doherty et al., 2004, p. 75). Yet, the social work students went beyond this and a third voice was expressed claiming that the whole issue of boundaries has less to do with the person’s identity, and is influenced more by one’s role and position in the organization (i.e. social workers vs. paraprofessionals) and by the nature of one’s contact with mental health consumers.

Rehabilitation and community services involve contact between providers and service users on a frequent basis. This intensity of contact challenges conventional therapeutic boundaries. As a result, the nature of such boundaries in rehabilitation services has become blurred, and open to personal and professional practical interpretation (Finaret & Shor, 2006; Moran et al., 2014b; Williams & Swartz, 1998). Having MHWLE discuss this issue in class helped the students reflect on their own boundary setting practices and thus contribute to their training and practice.

Summary: The importance of encounter and dialogue with MHWLE in the academic training of social workers

The integration of MHWLE in the workforce brings with it many advantages and opportunities, as well as complexity and challenges. It is also known to provoke thought and reflection about key professional issues by staff members in services (Chinman et al., 2008; Doherty et al., 2004; Miyamoto & Sono, 2012; Moran et al., 2013; Repper & Carter, 2011). In the current case study, MHWLE mere presence and sharing of their work experiences generate a challenge to basic conceptions (patient-therapist) and conventional professional attitudes (disclosure of personal experience in supervision and boundary settings). This encourages the students to self-reflect and re-think their own professional attitudes and practice.

Although MHWLE have become a phenomenon one cannot ignore, less attention has been devoted to their entrance into the workforce in training programs for social work practitioners. It is important to facilitate early encounters between practicing and future social workers with MHWLE outside of one’s workplace. Such an encounter can expose tensions and dilemmas, as well as areas of contradiction in viewpoints and experiences. It allows addressing the topic of integration of MHWLE in the system, and elaborations that encourage reflections into one’s own professional identity and practices as a mental health practitioner.

We believe that there is great value in creating pedagogic and research collaborations between MHWLE, field practitioners and academics. These collaborations will help implement current discourse and practice in the mental health field into training programs for social workers, thus better training and preparing them for the ever-changing field of mental health.

Note

1. We would like to note that we are aware that some of the confusion may have stemmed from lack of clarity regarding the role of MHWLE at the systemic and organizational levels. However, the conversation between the students extended way beyond this—it is this part of the confusion that we term ‘positive’.
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Disclosure statement

No potential conflict of interest was reported by the authors.

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