**Educational Activities**

The last three educational and professional activities and roles I performed are presented here in chronological order, with the most recent listed last.

**Head of the Mental Health System in the IDF (2005-2010)**

In 2006, I initiated a discussion that led to the drafting of a code of ethics for mental health officers (including psychiatrists) in the IDF, who are leaders in the profession in terms of overall responsibilities and authority over multidisciplinary teams. The project was sponsored by the Jerusalem Centre for Ethics (in the Mishkenot Sha'ananim neighborhood). I coordinated and was an active participant in all the discussions of a longstanding team that was also attended by the director of the Jerusalem Center for Ethics, Mr. Danny Milo, Prof. Asa Kasher, and Prof. Gabi Scheffler. Even before the code of ethics was launched about two years later, a significant number of mental health officers took active part in the thought and discussion regarding the principles of this code of ethics. Therefore, the code had already served as an educational compass for commanders in the IDF mental healthcare system for several years before it was officially adopted. The ethics code contributed to changing the primary role of the superintendent in the field, from merely sorting people into categories, to a true therapeutic figure who strives to strengthen individuals’ mental health and abilities, along with defining the commitment to patients and the organization's mission. In practice, the code’s principles contributed, during the time I was in this position, to two significant results:

The first was a significant reduction in the number and rate of suicides in the IDF. This resulted from, among other factors a significant expansion of the availability of caregivers, and the intensive involvement of an array of servicepeople with specific caregiving skills in training commanders to identify indicators of distress among their soldiers and to give early and supportive involvement. This is, in fact, an educational and training operation for commanders carried out, according to the spirit of the code of ethics, by mental healthcare officers at all levels (including my own, at the IDF Command and Staff College).

The second result was a significant narrowing in the scope of criteria for dismissal from the IDF due to mental distress. The result was a reversal of a multi-year trend of a significant increase in its rate. It should be emphasized that early dismissal from military service for mental/emotional distress has long-lasting implications in terms of social functioning, community, and self-image, especially for people who are members of disadvantaged populations. Unfortunately, unlike the first result mentioned above, this area of improvement eroded after the end of my service, and the multi-year trend was reversed again. Evidence of this appeared in an article published several years later by YNET (a major Israeli news outlet), on the recurrent rise in dismissals from IDF for mental distress, and its implications. The following data, published in the article, are not classified, and therefore I can cite it here (comments in parentheses are mine). The rate of dismissal from the IDF for mental distress among males was 17.3% in 2004 (a year before I took office). This rate began to decrease in 2007 and by 2009 (four years after I took office) it was 13.5% in 2009. The decrease lasted about four years. Then it began to rise again in 2012, and by 2014 had reached 16.5%. Among females in the IDF, the rate of dismissal for mental distress was 10.1% in 2004, dropped to 6.3% in 2008, and rose to 8.5% in 2014.

Another measure with educational value that I implemented was advancing first treatment in combat situations to the point closest to the front itself. This policy was put into practice during the Second Lebanon War in 2006, and in several military operations in the Gaza Strip. This was aided by my access to the field, as a former paratrooper. This process, which began as a temporary move, was led by professional and organizational entities, so the educational issue appears to be secondary. However, my belief in the educational and therapeutic dimension of forming a therapeutic alliance at the time and place of the traumatic event (backed by a theoretical professional approach), made the process more efficient and, it turns out, longer lasting.

**Head of Mental Health Services at the Ministry of Health (2010-2014)**

During the time I served in this position, I led the professional dimension in a process that led to an agreement between Israeli health maintenance organizations (HMOs) and the Ministry of Health regarding the transfer of responsibility for the provision of psychiatric services from the State to the HMOs. This eliminated the systemic distinction between mental healthcare (which had been under the responsibility of special services provided by the state) and general healthcare as provided through HMOs. This is one of several organizational and systemic efforts led by general director of the Ministry of Health. Alongside the professional and value-related dimensions, this process has an educational dimension related to the problem of social and personal stigmas related to mental health. An international study conducted at the initiative of the WHO in 2008 with the participation of sixteen countries, revealed that its severity in Israel is approximately twice as high as that typical in developed countries (!).

One of the factors that leads to stigmas and negative attitudes towards people suffering from mental distress is the separation between physical illness and mental illness, as expressed in the systemic separation that existed in Israel until the above-mentioned reform was enacted. For this reason, a coalition of organizations working on behalf of human rights and the rights of patients and their families has supported the advancement of this process.

Another issue in which I was involved that had an educational dimension, in addition to its professional and value-based dimensions, was the encouragement and active support for utilizing the medical system for the treatment of patients with suicidal tendencies. Many of these patients are sent for psychiatric hospitalization, but do not agree to it. Sometimes this refusal is legitimate and logical, given the absence of a legal reason for involuntary hospitalization (lack of existence of mental illness within the meaning of the law and relevant rulings). However, in such cases, their mental healthcare needs remain unanswered (see Appendix).

These examples are also connected to the effort of educating therapists to devote time and attention to addressing the cultivation of healthy lifestyles among hospitalized patients, such as giving them opportunities to engage in physical activity and spend time in nature. An expanding body of research indicates the therapeutic potential of exposure to nature, even when this variable is considered in isolation from other components in the more general category of ‘lifestyle’.

**Future Educational Goals**

In my opinion, one of the most significant educational challenges facing the world of psychiatry is the preservation of the holistic dimension of the profession, as an optimal therapeutic approach. Currently, an approach that considers psychiatric illness to be a “brain disease” is becoming more prevalent. Treatment options that rely on sophisticated neurobiological knowledge are expanding, such as various brain stimulation treatments, gene-targeted therapies, microsurgery, and more. I fully agree that expanding the therapeutic applications of accumulated scientific knowledge is important, necessary, and often exciting. However, I have noticed, among some of my professional colleagues, an erosion in the attention given to a holistic approach and to the important contributions of the interpersonal, humanistic, philosophical, and intellectual dimensions of our field. Conceptualizing a mental disorder as a brain disease, as opposed to a mental or emotional disorder, contributes to some psychiatrists developing an overly concrete perspective of the nature of the phenomenon. This damages the profession's affinity for the other dimensions mentioned above.

In order to address these trends, it is necessary to strengthen and deepen the full range of components that currently exist, such as the neuropsychiatry unit established about three years ago, and the level of training and instruction in psychotherapy (currently done quite successfully). In the future, we must expand our knowledge of and engagement with the world of rehabilitation and the perceptions of “recovery” on which it rests. This covers a realm of content that contains and balances all the dimensions and measures mentioned above.

Similar to the effort of renovating the Eitan campus, which was completed by my initiative, I intend to oversee the renovation of the program at the Kfar Shaul campus. This campus is located in the buildings from an Arab village, Deir Yassin, whose history in the War of Independence is one of the defining events in the Jewish-Palestinian conflict (historian and scholar Benny Morris titled his latest book *From Deir Yassin to Camp David*). The basics of the proposed program include:

* Establishment of an occupational and rehabilitation residential village named Yachdav (“Together”), which will be available to all residents of Jerusalem. It will be located in the village’s alleys and buildings, which will be carefully renovated and preserved, as required by law.
* Establishment of a gallery for various types of works of art (some of which have true artistic value), workshops, cafes, a restaurant, and other initiatives. The services and operation of this venue will be provided by people undergoing mental health rehabilitation, who will be trained and accompanied by mentors (a successful model for this exists in a restaurant in the city of Petah Tikva).
* Another positive and important aspect of this project will be its contribution to strengthening the value of communal life, expressing all the components of the special and fragile mosaic of the population of Jerusalem. The stones of the village serve as a silent testimony to the times when this has failed, and to the unbearable cost of such a failure, for all of us.

Thus, the charm of the place, together with the new life that this program will give to it, will be an anchor for preserving the threatened holistic dimensions of the profession. The challenge of strengthening these dimensions, together with its contributions to promoting the capabilities of advanced research (a neuropsychiatry unit is located in the northern wig of this complex), will serve as an inspiring model for tackling the complex educational challenge I mentioned at the beginning of this section. It will provide a tangible example of the holistic approach, which can be generated simultaneously, as a vision and as a tangible reality expressed on the ground.