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The Soteria model: implementing an alternative to acute psychiatric hospitalization in Israel

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ABSTRACT

Background: Since 2016, Soteria homes have been operating in Israel. In this report we describe the implementation of the model.

Methods: Data for 486 residents staying in one of three Soteria homes from 2016 through 2020 are presented. The model, and necessary modifications, are discussed.

Results: The majority of the residents in the Soteria homes suffered from psychotic (41.3%) or bipolar disorder (20.9%) and were of a mean age of 34.5 (SD = 12.83). While operating according to the principles of Soteria, adaptations had to be made. The homes used professional staff as well as companions. Accepting a wide range of residents exposed the home to situations of violent behaviour which required adjustment in admission policy. Work with insurers limited the possible length of stay. Financial constraints expanded the home capacity to 10 residents, while limiting work shifts to 12 hours. Cultural considerations led to the establishment of single-gender homes.

Discussion: Soteria homes can be a viable component of publicly-funded mental health care systems. The implementation of the Soteria model can provide important lessons for the future development of a professional and humane mental health care service – not as an alternative, but as an integral part of the system.

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Background

Soteria homes have been operating since the 1970s (Mosher, 1999). These homes, which provide care for individuals in acute psychiatric states requiring round-the-clock treatment, offer an alternative to a simplistic biomedical paradigm for understanding psychotic states. In particular, Loren Mosher, the psychiatrist who founded the first Soteria home, cultivated a culture of empathetic relations and non-intrusive interventions for the individual suffering from a psychotic break (Mosher et al., 2004). A recent formulation suggested eight basic principles for the functioning of Soteria: care is given in a home, not an institution; groups are small, eight or less; communication is open; activities are client-centered; treatment is consensual; medication is de-emphasized; staff learns to "be with" the resident empathically and non-judgmentally; and the group is the central therapeutic instrument (Lichtenberg, 2017).

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The Soteria model has spread worldwide, with several Soteria homes established, even though they have not always persevered, in the US, Switzerland, the Netherlands, Sweden, Germany, Japan (Ciompi, 2017), the UK, France (Turnpenny et al., 2018), and Hungary (Weber & Bugarszki, 2007) [19].

A growing body of research has spurred the search for alternatives to psychiatric hospitalization. In recent years, evidence has accumulated suggesting potential adverse long-term effects of psychiatric hospitalization, such as social stigmatization (Ho et al., 2018; Xu et al., 2019), impaired self-esteem or self-worth (Maharjan & Panthee, 2019; Mutschler et al., 2019), and social and occupational exclusion (Hengartner et al., 2017). This state of affairs has led to the call to develop and implement treatment alternatives that balance the biomedical model with a broader biopsychosocial approach to patients suffering from acute psychiatric distress (Lichtenberg, 2011). In 2017, the Human Rights Council of the United Nations recommended the Soteria model as a worthy treatment alternative to the biomedical excesses of psychiatric hospitalization, one that ought to be implemented worldwide (UN Human Rights Council, 2017). Indeed, several hospitalization alternatives have been developed and implemented in recent years (Lloyd-Evans et al., 2009), with most of them operating as community-based care. Notable amongst these are the open dialogue program in Northern Finland (Seikkula et al., 2011) which was later adopted in several countries (Freeman et al., 2019), and the crisis respite center in the US (Bouchery et al., 2018).

With this background, Soteria Israel, a non-profit organization, set up the first Soteria home in the Middle East in 2016 (Katz et al., 2019; Lichtenberg, 2017), and two additional homes subsequently. The importance of this initiative has been acknowledged by Israel's Ministry of Health (MOH), which following the establishment of our first home published guidelines for the establishment of short-term acute residential treatment homes (Israel Ministry of Health, 2019). About a dozen such homes currently operate in Israel.

Although alternatives to psychiatric hospitalization have proliferated in recent years, not many of them have reported on the process of implementation. Previous studies in different interventional areas suggest that implementation strategies are an imperative part of effective programs, and can actually predict the outcome of interventions (Durlak & DuPre, 2008). The actual implementation never occurs in a vacuum, but rather in a particular professional, organizational, and cultural environment, requiring its own adjustment to the original model. Indeed, reports of the implementation of psychiatric hospital alternatives have described several challenges, including safety, economic issues, and the acclimatization to residential neighbourhoods (Foot, 2014). These issues have required adaptations of the original models. For example, the original Soteria in northern California sought to integrate itself into the neighbourhood's community (Mosher et al., 2004), and Soteria Bern cultivated good relations with the professional community in its area (Ciompi et al., 2005).

The purpose of this report is to discuss in detail the establishment, implementation, and sustained functioning of Soteria homes in Israel. In order to provide an evaluation of the model, we will present descriptive data of the population served by our Soteria homes, and describe various challenges faced in the course of implementing the model.

Methods

We evaluated three Soteria homes: a men's home in Jerusalem operating since September 2016, a women's home in Jerusalem established in October 2017, and a mixed-gender home north of Tel Aviv ("Soteria Sharon"), set up in September 2019. To evaluate the residents' characteristics, anonymous data extraction was performed from the electronic resident record system. Data extraction was approved by the Institutional Helsinki Committee of Sheba Medical Center, number 8158–21-SMC. The Committee waived the requirement for informed consent, in light of the retrospective nature of the study, as well as the fact that all the data was coded and unidentifiable. Data were extracted in March 2021 and included demographic and clinical data of adult (18+) residents referred

to Soteria from September 2016 to the end of 2020. The following fields were extracted: age, gender, ICD-10 diagnosis, type of admission (first/readmission), duration of stay, number of stays, and transfer to psychiatric hospitalization.

Results

Characteristics of residents living in Soteria during the implementation period

A description of the demographic and clinical characteristics of the residents of the three Soteria homes treated in the implementation period (September 2016 to the end of 2020) is presented in Table 1.

As can be seen, 486 residents entered the three homes during the implementation period. The mean age of residents was 34.5 years (SD = 12.83), ranging from 18–81 years, with 276 (56.8%) men and 210 (43.2%) women. Diagnoses included the following: 301 (62.2%) were diagnosed with either a psychotic or bipolar disorder (F20-31, F06.3 according to the ICD 10); 70 (14.5%) were diagnosed with mood disorders (F32-F41); 69 (14.3%) were diagnosed with complex posttraumatic stress disorder (cPTSD: F43, F44, F60.3); and 44 (9.1%) with other disorders (two residents had missing data).

Description of implementation

To implement the Soteria model in Israel, crucial components of the original model were preserved while others had to be altered. While the original Soteria could house six residents, and we started with seven, economic necessity required us to increase capacity to 10 residents. We accepted individuals needing round-the-clock care with a wide range of diagnoses, not only psychotic disorders.

The heart of the staff remained the "companions", usually students or individuals with personal experience of acute emotional crises. Three worked 12-hour shifts during the day, two at night. These companions were instructed, as in the original Soteria, to cultivate a therapeutic community, with a warm and non-hierarchical atmosphere, blurring the differences between staff and residents. They were technically non-professionals, and each home provided intense supervision, including 2 hours of weekly group supervision, and one hour of individual supervision every other week.

On the other hand, in accordance with the requirements of the MOH and the demands of the insurers, and unlike the first Soteria (but akin to Soteria Berne), we maintained a full professional staff. Each home employed a half-time psychiatrist who was continuously on call; a psychiatric nurse, at least 10 hours per week; clinical psychologists, social workers, and possibly other mental health care

Table 1. Characteristics of the residents of the three Soteria homes.

	Jerusalem Male (n = 218)		Jerusalem Female (n = 152)		Sharon Male & Female (n = 116)		Total (n = 486)	
Description of residents	N	%	n	%	n	%	n	%
Age (M, SD)	32.40	11.1	37.35	14.8	34.60	12.4	34.50	12.8
Male (n, %)	218	100	0	0	58	50.0	276	56.8
Female (n, %)	0	0	152	100	58	50.0	210	43.2
Diagnoses (n, %)								
Psychosis (F20-29)	116	53.2	42	27.6	42	36.8	200	41.3
Bipolar (F30-31, F06.3)	42	19.3	29	19.1	30	26.3	101	20.9
Mood disorders (F32-41)	19	8.7	39	25.7	12	10.5	70	14.5
CPTSD (F43, F44, F60.3)	23	10.5	30	19.7	16	14.0	69	14.3
Other	17	7.8	12	7.9	14	12.3	44	9.1

Notes. Two residents had missing values; therefore, diagnosis rates were calculated among the remaining 484 residents.

workers such as psycho-dramatists or art therapists, totalling 90 hours a week between them. 2-hour weekly house staff meetings integrated the efforts of the professional and companion workers. A variety of volunteers also provided services for the home and its residents.

Meals were jointly prepared and shared as a natural space for encouraging spontaneous interpersonal interactions. Unlike the original Soteria model, residents in Israel's Soteria were provided with (though not required to participate in) a flexible daily routine.

At least one daily house meeting, conducted in an open style, as well as various therapy, activity, and support groups gathering several times a week, served as additional routes for encouraging open discussions. Spontaneous house meetings might also be convened in order to discuss a pressing problem for the community. The most meaningful exchanges could take place during chance meetings at the home, which might continue into the small hours of the night.

As required by the MOH, a treatment plan was developed for each resident. The weekly treatment program generally included at least one session with a psychiatrist, one with a psychologist or social worker, and one family session in the spirit of the model of open dialogue (Freeman et al., 2019). At least two staff members were present during these family meetings, where therapeutic goals were discussed and planned.

The language of psychiatric diagnosis, though unavoidable in communicating with regulators and insurers, was not a part of the discussions in the home. Moreover, medication was not considered the first-line of treatment, and when used, was understood to be mainly symptomatic treatment – drug-centred and not disease-centred (Moncrieff, 2018). Its use was not forbidden (contrary to the original Soteria during the first six weeks of the stay), nor was it mandatory, except in exceptional cases where there was a concern for the safety of the residents or their environment. As with all treatment decisions, considerations pro and con were discussed candidly with the resident.

Safety procedures were set by the MOH, requiring that residents be monitored during entry to and exit from the home. Accordingly, the entrance door was locked. Residents were however encouraged to walk around the neighbourhood, usually with companions at their side.

Joint meetings of the staff of the three homes occured infrequently, yet the ethos of care developed in all three homes was remarkably similar; the differences were mainly a result of the different composition of residents in the three homes: all men, all women, or mixed-gender.

Special challenges

Management of risk

The most critical challenge faced by the Soteria homes was the management of acute psychiatric states involving violent behaviours and suicidality. In the most extreme situations, the resident had to be transferred to an inpatient ward in a psychiatric hospital, sometimes involuntarily (Table 2). As can be seen, 68 (14.0%) of the 486 residents were transferred to hospitals during their stay at Soteria because of an acute state. Of the 68 residents who were hospitalized, 34 (50.0%) suffered from a psychotic episode, 19 (27.9%) had a bipolar disorder, six (8.8%) had complex posttraumatic stress disorder (cPTSD), five (7.4%) had mood disorders, and four (5.9%) had other disorders. During the implementation period, the most challenging events predominantly occurred in patients undergoing a severe manic episode, either with or without psychotic features.

It should also be noted that during the implementation period, one resident committed suicide. This tragic event, coupled with the difficulty of managing in-house acute states, resulted in several changes aimed at improving the management of acute states. Overall number of hospitalizations subsequently decreased (see, Figure 1 for illustration).

As can be seen, over the years the number of hospitalizations occurring during the first stay at Soteria decreased substantially, from 37.5% (six out of 16) residents hospitalized in 2016 to 8.3% (16 out of 192) in 2020 ($\chi^2 = 13.284$, $p < .0003$). Changes aimed at improving the management of acute states included closer supervision of suicidal residents and adjustment of the entrance criteria to Soteria. While no single past act would automatically preclude the candidate from joining us as

Table 2. Characteristics of the stay in the three Soteria homes.

Description of stay characteristics	Jerusalem Male (n = 218)		Jerusalem Female (n = 152)		Sharon Male & Female (n = 116)		Total (n = 486)	
	n	%	n	%	n	%	n	%
First Soteria stay								
Duration of stay (days; M, SD)	41.15 (45.29)		43.84 (47.91)		27.21 (28.44)		38.6 (43.18)	
Psychiatric ward transfer (total)	36	16.5	24	15.8	8	6.8	68	14.0
Transfer by diagnosis								
Psychosis (F20-F29)	22	61.1	8	33.3	4	50.0	34	50.0
Bipolar (F30-F31, F06.3)	12	33.3	4	16.7	3	37.5	19	27.9
Mood disorders (F32-F41)	0	0.0	4	16.7	1	12.5	5	7.4
CPTSD (F43, F44, F60.3)	0	0.0	6	25.0	0	0.0	6	8.8
Other	2	5.6	2	8.3	0	0.0	4	5.9
Second Soteria stay								
Arrival for second stay (n, %)	52	23.9	20	13.0	19	16.4	91	18.7
Duration of second stay (M, SD)	30.66 (31.35)		58.13 (55.07)		18.99 (14.60)		34.63 (8.07)	

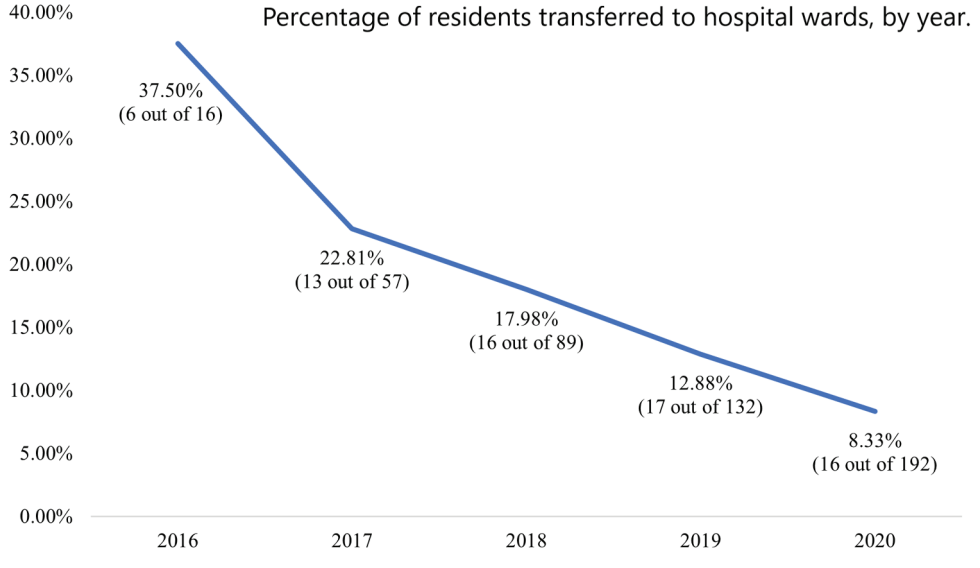

Figure 1. Percentage of residents transferred to hospital wards, by year.

a resident, we would question more carefully individuals who had recently made a serious and intentional attempt to end their lives, in the hope of ascertaining degree of cooperation and honesty, assessing the potential for a therapeutic alliance, and, on occasion, demanding cooperation with taking medication. Whereas during the first year of implementation the Soteria home allowed residents to choose whether to take medications, policy was modified and residents exhibiting violent tendencies towards themselves or others could be required to take medication during their stay. Residents who were coping with psychosis without violence could choose, following an open discussion, whether to take medication or not, as in the original Soteria.

Administrative issues

Even before we established our first Soteria home, our goal was not to make do with a lone home serving as a boutique for well-heeled clients, but rather to produce a sustainable model which could dialogue with the public mental health care system, of which we strove to become a part. But it was

clear to us that in order to attract public pay, we could not be more expensive than a hospital stay, lest we drive away the insurers. This meant that Soteria's per diem costs must be competitive with those of the standard inpatient alternative, despite boasting a higher staff:patient ratio than hospitals. This was achieved by the preponderance of non-professional staff with a minimal nursing staff. Moreover, average length of stay could not significantly exceed that of the hospital system. This strategy paid off, and the Soteria homes, which were initially funded by philanthropy, and later mostly by out-of-pocket payments, subsequently managed to sign contracts with two of the four Israeli health care insurers, so that only a small and dwindling minority of residents continued to be self-pay.

This adaptation to the system meant that unlike the original Soteria, where residents stayed between three months to half a year on average (Mosher et al., 2004), the average length of stay at Soteria Israel was a mean of 38.6 days (SD = 43.18). It is likely that the shorter duration of stay in our homes increased the need for a second Soteria stay. During the implementation years, 91 (18.7%) of the 486 residents required readmission in one of the Soteria homes (see, Table 2). The mean stay for the second admission was 34.6 (SD = 38.07) days; no significant difference was found between the mean duration of the first vs. the second stay ($t [86] = 1.558$, $p = 0.12$).

Integrating into the community

Providing housing for people in need of acute psychiatric care within a residential community is not to be taken for granted. We did not preempt problems by initiating meetings with the neighbors, for fear that they might act to somehow prevent our work, but quickly enough the need to maintain good relations with them became apparent. We occasionally received complaints about noise, dirt, or parking, and we responded responsibly and empathically. On occasion we found ourselves sitting in the neighbors' living rooms and explaining to them who had moved in next door. Once the neighbors understood the importance of what we were doing, were provided with the telephone number of staff who would patiently handle the occasional complaint, and trusted our desire to be as little disruptive as possible, they generally accepted our presence. We had to remember to refrain from leaving on the outdoor spotlight overnight, and we were careful not to invade their parking spaces. Once a women climbed upstairs from outside the building onto a neighbor's balcony, removed her clothes, and threatened to jump, until the staff succeeded in talking her down. This was difficult for the neighbors and required longer discussions with them. In all, solving friction with neighbors was considered not an irksome task but rather an opportunity to advance our agenda of tolerating madness within society. In addition, our location in the community allowed us to forge partnerships with various social and recreational services in the area.

Cost considerations

Several of the characteristics of the original Soteria model could not be implemented due to their high costs. For example, in the original Soteria, companion shifts would last a day or more (Mosher et al., 2004), and in Soteria Bern they continue for 48 hours (Ciompi, 2017). The goal of the long shifts is to provide a sense of continuity and a homey atmosphere for the residents. In Israel, though we started with 24-hour shifts, labour costs and labour laws combined to force us to change to 12-hour shifts. In order to minimize the sense of staff turnover common in institutions, and to increase the sense of continuity, Soteria tried to stagger shifts so that two companions would not go off duty at the same time.

Cultural considerations

Another modification from the original model stems from cultural issues in Israel. Jerusalem's significant traditionally observant Jewish population was a major consideration in establishing two gender-segregated homes in the city. On the other hand, the greater Tel Aviv area is characterized by a more secular population, and the home established there was mixed-gender. Because of the

need to accommodate religion-based food restrictions, in particular the cumbersome religious requirement to separate meat and dairy products, all Soteria homes in Israel are vegetarian or pescatarian.

Discussion

In this report we presented the implementation of the Soteria model in Israel, the first residential alternative to acute psychiatric hospitalization offered in this country. We have summarized the experience accumulated in the first four and a half years of its operations, spanning three homes. We have also discussed the adaptations to the original model. Soteria homes have been shown to be a viable alternative to institutionalization for a wide variety of people requiring around the clock psychiatric care, in particular for people in psychotic states.

Our accumulated experience in implementing the Soteria model led to several modifications. The Israeli model was open to all psychiatric diagnoses due to the desire to serve a larger population. This probably increased the number of residents in our care whose aggressive behavior towards self or others threatened to exceed the capacity of the home to handle. In particular, people in manic states or with a background of severe trauma can be particular challenges to the homes' functioning, and a disproportionate cause of the need for hospitalization (Bryan, 2016; McIntyre et al., 2020). This challenge necessitated a more critical assessment of people seeking to receive care in Soteria. Of course, one can never predict clinical developments, and that is why the homes, in a departure from standard Soteria practice, occasionally demanded adherence to a medication regimen as a condition for remaining in the home. These steps contributed to the gradual decrease in number of psychiatric hospitalizations from Soteria, from an intolerable 37.5% of the residents at the start of our operations, to 8.3% in 2020, which is more in line with what happens in other Soteria homes (Fenton et al., 1998).

The reader will be forgiven for thinking that we should have realized in advance the risks involved in accepting suicidal residents into the home. In our defence, we would say that we began with deep enthusiasm and overweening confidence about our abilities to contain the most extreme emotional states through respect and deep empathy. The reality has been sobering, and led to thoughts about the possibility, or perhaps necessity, of developing inpatient Soteria units (Wolf et al., 2021).

Financial considerations are of course a factor impeding the development of Soteria homes, and always have been: the original Soteria was closed in 1983 due to budget cuts, despite reports of consistently positive results (Matthews et al., 1979; Mosher & Menn, 1978). Mosher (1999) attributed the lack of public funding to the regnant biomedical model of the psychiatric community. As noted, we also kept the length of stay in Soteria relatively brief compared with the original Soteria, in order to not to be more expensive than standard hospitalization. Soteria Berne found it necessary for similar reasons to reduce the average length of stay of its residents (Ciompi, 2017).

We have reason for optimism, as there appears to be a tectonic shift in the paradigms undergirding mental health care, bringing greater openness to new approaches and a re-examination of forgotten wisdom (Gardner & Kleinman, 2019; Middleton & Moncrieff, 2019).

In Israel, while the first years of implementation in Israel showed the same pattern of a struggle for recognition and funding (Lichtenberg, 2017), in 2017 the MOH recognized the model, developed the necessary guidelines, and provided the legal and regulatory basis for funding by insurers. Since then, about ten more homes based on those guidelines have been established, providing a community-based residential care alternative to acute psychiatric hospitalization. The extent of public funding has also grown, as all four health maintenance organizations providing medical insurance to all citizens offer an option for full coverage for the service in some of these homes.

Our report has certain limitations. We describe the functioning of the home and some results, such as the necessity to transfer residents to hospitals. However, there is not an attempt here to methodically and prospectively assess outcomes, nor is there a comparison group comprised of a similar population. And the writers can reasonably be suspected of viewing activity at Soteria through rose-coloured lenses; they are not impartial raters.

The results presented in this report bear important clinical and practical implications. First of all, our work joins a small but growing body of evidence that implementation of a Soteria model as an alternative to psychiatric hospitalization is feasible (Mosher & Menn, 1978; Ciompi, 2017; see review in Calton et al., 2008). Together, these works build a strong case for developing Soteria-type facilities, where those requiring round-the-clock psychiatric care can be treated, not with a narrow biomedical paradigm which views emotional distress as a brain disease, but rather with a rich interpersonal support system and therapeutic community where priority is given to open communication, respect for the individual, a broad focus on the human sources of suffering, and anticipation of recovery.

A further accomplishment of Soteria in Israel is that rather than remaining a single home operating as an alternative and remaining marginal to the system, we have succeeding in becoming a part of the system and establishing more homes. This was accomplished with certain compromises – we shortened the length of stay, employ a professional staff in addition to non-professional companions, and accept the need for medication in certain circumstances – but we maintained fealty to the core principles of Soteria (a manuscript attempting to elucidate these principles is in preparation). This suggests that with the necessary accommodations for the local professional, organizational, and cultural environment, the Soteria model can be integrated into existing public mental health care systems. The ten community-based short term acute residential treatment established by other groups in Israel, though not exactly Soteria, are far more similar to Soteria than to the inpatient wards they hope to replace.

Finally, having demonstrated that the concept of Soteria can work within a conventional mental health care system and influence it from within, it is tempting to consider whether the principles of Soteria can be replicated in other settings, not only in the community, but even in closed and forensic wards, though they may appear most inimical to what Soteria seeks to do. Might people involuntarily incarcerated in forensic psychiatric departments, for example, also benefit from the therapeutic culture cultivated in Soteria?

Clearly, as always, further research is needed, in order to characterize more precisely the people who can be spared institutional care and remain in a Soteria or Soteria-inspired home in the community. Future initiatives should also compare more rigorously the outcomes of psychiatric hospitalization alternatives compared with standard institutional care. As remarked above, the possibility of providing treatment consistent with the principles of Soteria within an inpatient psychiatric ward should be further investigated, in order to reach a population which cannot or will not stay in a Soteria home in the community.

We do believe that we offer here an important correction for the way much of psychiatry treats the most distressed individuals in its care. Our work suggests a path for the future development of a responsible, professional and humane mental health care service – not as an alternative, but as an integral part of the system.

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