LETTERS

Family-Friendly Services: A Modest Proposal

To the Editor: Numerous studies show that family collaboration with mental health professionals improves the long-term outcome of persons with severe mental illnesses (1,2). Nevertheless, community mental health centers (CMHCs) provide few services to families (3), and true collaboration remains an unattained goal.

Different explanations have been offered to account for the lack of family services, such as theories that blame families for mental illness, limited funding, and a lack of training in family work for professionals. However, these explanations have not led to an increase in the services provided to families. We posit a new hypothesis for the failure to implement evidence-based practices for family collaboration and propose a solution to this problem.

We suggest that the major obstacle to implementing family-friendly services at CMHCs is the absence of specific individuals who have the authority to see that family services are provided. With no single person in an agency responsible for ensuring that family collaboration happens, responsibility is diffused, services are not provided, and families remain in the dark about their loved ones.

To address the need for accountability, we propose that each CMHC designate an individual as the director of adult family services. This person would be empowered by the agency to ensure that appropriate, culturally competent, and collaborative services are provided to families of persons with serious mental illness. The director must have the administrative authority to implement family services and the support of the leaders of the agency.

Depending on the size of the CMHC, the directorship would be a quarter-time to a full-time position. In addition, funds would need to be budgeted to support the continuing growth of the director's expertise in family services and to train other clinicians. For example, funds would go toward educational materials, attendance at conferences, and membership in professional organizations.

We developed the following position description.

The primary functions of the director of adult family services are to develop, coordinate, and oversee services provided to the families of consumers with severe mental illness in the community support program. The person must have experience working with families of adult persons with severe mental illness, including parents, spouses, and children of clients, and must be able to train new clinicians in the principles and practice of family work. The director is expected to perform the following tasks:

♦ Identify and train clinicians in family work

♦ Lead and supervise family work

♦ Monitor the delivery of family services

♦ Develop, implement, and oversee family programs

♦ Work with a family advocate as a liaison with the National Alliance for the Mentally Ill

♦ Participate in continuing education activities.

Many CMHCs recognize the importance of providing services for specific areas, such as vocational rehabilitation and dual disorders, and have established directors of services in these areas. We propose a similar position for family services for adults with severe mental illness. By establishing a director position, CMHCs will formally acknowledge the importance of families and hold themselves accountable for providing evidence-based family services for their clients. Families and service providers have much to gain through developing collaborative relationships. We believe that our modest proposal is crucial for bridging the gap between the lip service currently given to family collaboration at most CMHCs and the provision of truly collaborative, family-friendly services for persons with severe mental illness.

Kim T. Mueser, Ph.D.
Lindy Fox, M.A., C.A.D.A.C.

Dr. Mueser and Ms. Fox are affiliated with the New Hampshire–Dartmouth Psychiatric Research Center in Concord, New Hampshire.

References

1. Dixon L, Adams C, Lucksted A: Update on family psychoeducation for schizophrenia. Schizophrenia Bulletin 26:5–20, 2000

2. Mueser KT, Glynn SM: Behavioral Family Therapy for Psychiatric Disorders, 2nd ed. Oakland, Calif, New Harbinger, 1999

3. Dixon L, Goldman H, Hirad A: State policy and funding of services to families of adults with serious and persistent mental illness. Psychiatric Services 50:551–553, 1999

The Mentally Ill Poor: Rethinking Ethics

To the Editor: I am one of many community psychiatrists who believe that caring for the mentally ill poor population is an ethical obligation rather than a charitable option. I am just not sure anymore how to explain the basis of this moral responsibility. Recent contributions to *Psychiatric Services*, such as those in the special section on caring for the least well off in the May 1999 issue, have attempted to address this issue by providing both historical and ethical arguments for allocating care to the least well off in our communities (1,2).

Appeals to conventional moral

rules and principles of resource allocation, however, may no longer suffice. Just as market forces are changing the way in which mental health care is being allocated, so too are they changing the way in which we think about applied medical ethics. I agree with Daniel Callahan (3), who argues for alternative approaches to developing a moral justification for allocating resources to those who frequently walk in the shadows of the public mental health care system. For example, the ethical principles of beneficence, autonomy, and justice have traditionally centered rather narrowly on the physician-patient relationship to the exclusion of examining organizational values and commitments.

The same can be said for professional codes of ethics. Ezekiel Emmanuel (4), acknowledging the influence managed care has had on health care delivery, noted, "The advent and explosive growth of managed care has dramatically and irreversibly changed the nature of medical practice, and therefore the context in which ethical issues arise. . . . Interactions occur within organizations in which the practitioner or a small group of colleagues no longer control the rules of engagement. The context of medical ethics can no longer be cases, but institutional structures." Hence, when articulating community psychiatry's moral responsibility to the least well off in society, I would argue that the moral analysis should be expanded to include an examination of the ethical values of the mental health organizations in which we practice.

Three values understood to be moral commitments that define the practices and policies of a particular organization have long been embedded within a compassionate community mental health tradition of providing care to the poor: humaneness, fairness, and social responsibility. Identifying and invoking these values on an organizational level broadens the grounding of a moral obligation to treat the most vulnerable members of society.

Humaneness as an institutional value directs policies and practices that promote a sense of benevolence to people in general as well as compassion for people in need. For example, an evaluation of the moral acceptability of the managed care contract of a community mental health center (CMHC) would take into account the impact of such arrangements on those with the greatest need and the fewest resources.

Fairness on an institutional level would require a CMHC to critically evaluate how it distributes its limited resources. Financial considerations in setting allocation priorities at the beginning of every fiscal year would be tempered with concerns about need, opportunity, and therapeutic benefit for those on the margins of inclusion.

Social responsibility is a central value to the organizational tradition of CMHCs. A CMHC that values social responsibility will inform its practices with a respect for its obligations to the social community in which it exists. Caring for a community's mentally ill poor population would be an exceptionally high priority, and setting such a priority would likely put a brake on socially irresponsible referrals to free clinics, primary care practices, or other resource-limited agencies that are less capable of meeting the needs of this population.

Who will care for the mentally ill poor population? The ethical basis for a community psychiatrist's commitment to serve marginalized persons ought to go beyond principle-based ethics directing individual choice and find roots within organizational values and structures. Indeed, the lives of those without a voice or resources depend on these institutional commitments.

Richard C. Christensen, M.D., M.A.

Dr. Christensen is assistant clinical professor and director of the community psychiatry program at the University of Florida College of Medicine in Jacksonville.

References

1. Rosenheck RA: Principles for priority setting in mental health services and their implications for the least well off. Psychiatric Services 50:653–658, 1999

2. Goldman HH: The obligation of mental health services to the least well off. Psychiatric Services 50:659–663, 1999

3. Callahan D: Balancing efficiency and need in allocating resources to the care of persons with serious mental illness. Psychiatric Services 50:664–666, 1999

4. Emmanuel EJ: Medical ethics in the era of managed care: the need for institutional structures instead of principles for individual cases. Journal of Clinical Ethics 6:335–338, 1995

Jerusalem Syndrome or Paranoid Schizophrenia?

To the Editor: We were intrigued to read the case report by Dr. Fastovsky and her colleagues in the August 2000 issue (1). As the authors of several articles on Jerusalem syndrome, we would like to add our comments. Contrary to the opening statements in Dr. Fastovsky's letter, attempts to present the so-called Jerusalem syndrome as a distinct clinical entity have been severely criticized (2). In our view, Jerusalem syndrome should perhaps be regarded as a unique cultural phenomenon because of its overwhelming theatrical characteristics (3). Dramatic cases have been reported by various biographers since the establishment of pilgrimages to the Holy City and tourism (4), and such cases are appealing to today's media.

Our accumulated data indicate that Jerusalem should not be regarded as a pathogenic factor, because the morbid ideation of the affected travelers started elsewhere. Jerusalem syndrome should be viewed as an aggravation of a chronic mental illness and not a transient psychotic episode (5). The eccentric conduct and bizarre behavior of these colorful but mainly psychotic travelers become dramatically overt once they reach the Holy City—a geographical locus containing the axis mundi of their religious beliefs.

The case presented by Dr. Fastovsky and colleagues demonstrates our basic assumptions. In our view, their patient was experiencing an aggravation of paranoid schizophrenia. The content of the patient's delusions and his overt behavior were colored by his cultural-religious background.

Moshe Kalian, M.D.
Eliezer Witztum, M.D.

Dr. Kalian is the district psychiatrist in the Ministry of Health in the Central District of Israel in Ramle. Dr. Witztum is professor of psychiatry at the Negev Faculty of Health Sciences at the Mental Health Center in Beer Sheva.

References

1. Fastovsky N, Teitelbaum A, Zislin J, et al: The Jerusalem syndrome (ltr). Psychiatric Services 51:1052, 2000

2. Kalian M, Witztum E: Comments on Jerusalem syndrome (ltr). British Journal of Psychiatry 176:492, 2000

3. Witztum E, Kalian M: The quest for redemption: reality and fantasy in the mission to Jerusalem, in Israel as Center Stage: A Setting for Social and Religious Enactments. Edited by Hare PA, Kressel GM. Westport, Conn, Bergin & Garvey, 2000

4. Witztum E, Kalian M: The "Jerusalem syndrome"—fantasy and reality: a survey of accounts from the 19th century to the end of the second millennium. Israel Journal of Psychiatry 36:260-271, 1999

5. Kalian M, Witztum E: Facing a holy space: psychiatric hospitalization of tourists in Jerusalem, in Sacred Space: Shrine, City, Land. Edited by Kedar BZ, Werblowsky RJZ. New York, New York University Press, 1998

In Reply: The issue raised in our communication to *Psychiatric Services* is not whether the Jerusalem syndrome is a "distinct clinical entity" or whether the city of Jerusalem should be regarded as a "pathogenic factor," as implied in Dr. Kalian and Dr. Witztum's letter. Rather, our letter described a case in which an objectively verifiable syndrome simultaneously served as a paranoid delusional object—the "Jerusalem syndrome organization."

Our initial account of Jerusalem syndrome (1) clearly distinguished between patients with Jerusalem syndrome who also have a history of psychotic illness—Jerusalem syndrome superimposed on a previous psychotic illness—and those with no previous psychopathology, whom we referred to as having the discrete form of the syndrome. In either case, the symptoms of the syndrome appear on arrival in Jerusalem and exposure to the holy places. The patient described in our communication suffered from Jerusalem syndrome superimposed on paranoid schizophrenia. Proximity

to the holy places of Jerusalem clearly triggered the full sequence of his symptoms.

Dr. Kalian and Dr. Witztum, who have previously expressed their objections to our description of Jerusalem syndrome (2), wrote elsewhere (3) that "the study of the psychopathology of those who do suffer mental breakdowns in a particular place has yielded important observations and deductions." They described travelers who "had a psychotic episode while visiting Jerusalem" and argued that "there is clearly a correlation between the meaning of Jerusalem as a place central to religious experience and the nature of the psychotic episode." They have also stated, as they do in their letter, that "the eccentric conduct and bizarre performance of these colorful yet psychotic visitors became dramatically overt once they reached the Holy City—a geographical locus containing the 'axis mundi' of their religious belief " (4).

We have no quarrel with Dr. Kalian and Dr. Witztum about the strong cultural-religious background of Jerusalem syndrome, and we have argued elsewhere for the importance of taking such factors into account (1).

As a syndrome rather than as a distinct nosological entity, Jerusalem syndrome may appear in the context of other major psychiatric disorders or as a de novo psychotic condition. We are confronted by such patients regularly in our mental health center in Jerusalem, the psychiatric facility to which virtually all tourists suffering psychotic breakdowns while in the Jerusalem area are referred for treatment.

Natasha Fastovsky, M.D.
Alexander Teitelbaum, M.D.
Josef Zislin, M.D.
Gregory Katz, M.D.
Rimona Durst, M.D.

The authors are psychiatrists in the Kfar Shaul Mental Health Center in Jerusalem, which is affiliated with the Hadassah Medical School of Hebrew University.

References

1. Bar-El Y, Durst R, Katz G, et al: The Jerusalem syndrome. British Journal of Psychiatry 176:86–90, 2000

2. Kalian M, Witztum E: Comments on Jerusalem syndrome (ltr). British Journal of Psychiatry 176:492, 2000

3. Kalian M, Witztum E: Facing a holy space: psychiatric hospitalization of tourists in Jerusalem, in Sacred Space: Shrine, City, Land. Edited by Kedar BZ, Werblowsky RJZ. New York, New York University Press, 1998

4. Witztum E, Kalian M: The "Jerusalem syndrome"—fantasy and reality: a survey of accounts from the 19th century to the end of the second millennium. Israel Journal of Psychiatry 36:260–271, 1999

Coming in December

♦ **An interview with Leona Bachrach**

♦ **A roundtable discussion about the next 50 years of providing psychiatric services**

♦ **Living with schizophrenia: the perspectives of women**