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CORE VALUES IN ACTION: THERAPEUTIC FARMS FOR PERSONS WITH SEVERE MENTAL ILLNESS

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Core Values in Action: Therapeutic Farms for Persons with Severe Mental Illness

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Abstract

The development of asylums in both Europe and the United States grew out of a social reform movement that sought to improve the living conditions of less fortunate persons and a belief that man could improve his condition by engaging with greater meaning with his social and physical environment. Accordingly, it was believed that mental health impediments could be overcome or removed by creating a healing environment that facilitates the sufferer's re-engagement into purposeful community life. Moral treatment, practiced in the United States and Europe during the period from 1815 to 1875, reflected this benevolent intent. This approach was intended to foster and sustain intimate, supportive relationships between the 'less fortunate persons' ("residents") and the staff through resident engagement in productive labor such as agriculture, resident respite in a peaceful setting away from the usual stresses of daily life, and the development of emotionally close and trusting relationships between staff, between residents, and between residents and staff. This therapeutic milieu, the 'asylums', ultimately could not be sustained over long periods of time due to growing numbers of mentally ill persons, diminishing financial resources, and increasingly diverse resident populations, ineffective organizational leadership and shifting political priorities.

Therapeutic farms for mentally ill persons that are premised on the principles of moral treatment methodologies applicable to 21st century needs and resources have

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been established more recently in the United States, Canada, and Europe. Like the therapeutic farms in past centuries, present-day therapeutic farms face financial, leadership, legal and political challenges that threaten their continued existence. This article reviews the moral values underlying moral treatment and the therapeutic farm community model and the efforts of present-day therapeutic farms both to advocate on behalf of their residents and to develop approaches to sustain their core values and meet existing challenges.

Keywords:
Moral treatment; mental illness; asylum; advocacy; social action.

The European Origins of Moral Treatment

The concept of moral treatment derived from the beliefs and practices of Philippe Pinel in France and William Tuke in England during the mid-nineteenth century. Their approach to the treatment of mental illness became the foundation of care for persons with severe mental illness in Western Europe, the United States, and Canada. Enthusiasm for this approach reached its zenith between 1830 and 1850 (Dain, 1964). Unlike their predecessors and some of their contemporaries, who viewed mental illness from a theological perspective, both Pinel and Tuke understood the illness as the result of psychological and medical factors. Pinel, in particular, was aware of the adverse impact of mental illness on its sufferers, stating, „Of all the afflictions to which human nature is subject, the loss of reason is at once the most calamitous …" (Pinel, 1906: xv).

Pinel believed that moral treatment consisted of the use of „intimidation, without severity; of oppression, without violence, and of triumph, without outrage" (Pinel, 1906: 63). He advocated kind treatment, participation in labor, personal liberty consistent with safety, and a level of mildness or firmness that was appropriate to each individual situation.

Tuke also advocated treating mentally ill persons with kindness and fashioned a system of „moral management" that included attendance at worship services, entertainment, and occupational therapy. He decried the use of treatments that were then provided by meany of his contemporaries. These treatments, which included bleeding, blisters,

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and evacuants, often did more harm to the patient than good (Dain and Carlson, 1960: 278).

Tuke established the York Retreat for the treatment of mentally ill persons. Tuke, like Pinel, believed that individuals would be more likely to recover from their mental illness if they lived in a family-like atmosphere, in contrast to the usual practice then of chaining individuals in facilities if they could not be cared for by relatives. The staff of the therapeutic community lived on the premises with their families and shared meals with the patients.

Moral Treatment in the United States

The concept of moral treatment was brought to the United States by Benjamin Rush and Eli Todd, both of whom had attended school in England and became familiar with Tuke's approach (Wood, 2004). The concept was soon championed by Dorothea Dix (Luchins, 2001) and, by 1841, the United States had 16 moral treatment asylums that were fashioned after those that had been developed in Europe (Taubes, 1998).

The idea of moral treatment took hold during a period of social reform that focused on improving the living conditions of persons considered to be among the less fortunate (Grob, 1966, 1973). This period of time was characterized by both a religious revival and new understandings of mental illness. During this religious revival period, Christians were challenged by their churches to save the souls of their community members and to concentrate their efforts on saving humanity and purifying American society. The ultimate goal was nothing less than the perfection of individuals and of society through the purging of corruption and the eradication of abuses, e.g. slavery and vice, all in preparation for the coming millennium. One Unitarian minister declared that "a healthful moral influence" was needed to prevent and remedy the unhealthful situations that could predispose individuals to mental illness (Rothman, 1971: 73). In contrast to previous notions of the inevitability of deviance, it was now believed that man could improve his condition by engaging with greater meaning with his social and physical environment and, by doing so, transform an ill-ordered, evil life into one of stability, thereby ensuring that good and order would prevail.

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As ideas of the Enlightenment took hold, understandings of crime and deviance as the result of man's nature and Satan's influence gave way to a belief that deviance—criminal acts, drinking, and other social vices—was the product of a poor family upbringing and unhealthy environment. Mental illness came to be understood as a physical illness, a disease of the brain, rather than the result of demonic possession.

The principles of moral treatment included:

- Mental illness can be cured.
- Patients are rational beings.
- Punishment should be avoided and reward emphasized.
- Physical restraint is to be avoided.
- The environment must be structured, with opportunities for both labor and socialization.
- Patients are to be provided with an intimate, family-like environment.
- Respite from the stresses of everyday life is needed to foster recovery.

The majority of therapeutic farm communities accepted no more than 30 patients at one time, in order to provide individualized care to each person and address their specific needs.

Although physical restraint was to be avoided, sometimes it became necessary if the patient was violent. Depending upon the particular facility, seclusion, binding, or bleeding might be used to try to calm the individual. By 1856, opium and other drugs were used instead.

It was believed that moral treatment required moral architecture (Francis, 1977). The building, which was considered to be an instrument of treatment (Scull, 1981), was to be located in tranquil setting to allow patients to escape the chaos of everyday life (Edginton, 1994, 1997). The farm community was to have walks, woods, gardens and orchards (Digby, 1985).

The practice of moral treatment, however, was not sustained over time. Fiscal responsibility for mentally ill persons was shifted from the local communities to the state government. State governments placed their priority on custodial care, protection of the public, and saving money. Effective leadership was not sustained. The facilities quickly became overcrowded and, as a consequence, the individualized care that had characterized the moral treatment approach became impossible. The overcrowded facilities often lacked adequate hygiene

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and appropriate mental health treatment; abuse was not uncommon. Later, the development of new medications for serious mental illness during the 1950s and recognition of the rights of mentally ill persons in the 1960s and 1970s prompted the deinstitutionalization of many individuals. As mental hospitals closed, individuals who had been in the hospitals were supposed to obtain services in the community, but community mental health services were often underfunded and unavailable. Many individuals became stuck in a "revolving door," whereby they would receive emergency mental health care at a hospital, were quickly released, but then were unable to find services in the community. As their condition once again deteriorated and they became a risk to themselves or others, they again would be taken to a hospital. The phenomenon of transinstitutionalization has been steadily increasing, whereby growing numbers of individuals are incarcerated due to criminal offenses that in some cases are directly attributable to the symptoms of their mental illness. For example, estimates suggest that in 2008, U.S. prisons and jails housed 316,000 individuals with mental illness and one-half of all state and federal prisoners and 60% of all jail inmates had mental health difficulties (Raphael and Stoll, 2013).

Moral Treatment Principles and Therapeutic Farm Communities Today

Today's U.S.-based therapeutic farm communities are often premised on the same principles as the original therapeutic farm communities: the belief that individuals can be helped to achieve their potential, the importance of manual labor and development of skills, the provision of mental health care, location in a peaceful environment, the development and maintenance of a family/community-like atmosphere, and a prohibition against physical restraint. A belief in the possibility of recovery from mental illness is key to both the philosophy and the programming of the therapeutic farms. The concept of recovery refers not to a cure in the sense of eradication of the illness, but rather to a restored capacity to engage with and be a part of a network of family, friends, and/or community, to recognize and manage one's symptoms, and to find meaning and purpose in and for one's life.

In Europe, the therapeutic farms are known variously as care farms, care farming, green farms, social farming, and "green care" in agriculture. Unlike the farms in the U.S., the development of European

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farms has been fueled by socioeconomic changes occurring in European agriculture and rural areas and the concomitant need to adapt to such changes (Dessein, Bock, and de Krom, 2013: 50). Most of the care farms operate from either a public health or a social inclusion framework (cf. Dessein, Bock, and de Krom, 2013). The public health frame emphasizes the potential benefits that can be derived from the provision of physical and spiritual experiences in a natural setting that encompasses seasonal cycles (De Bruin et al., 2010; De Vries, 2006). The social inclusion framework recognizes that persons with mental illness, as well as others, may have been excluded from the larger society (Dessein, Bock, and de Krom, 2013) and seeks to help them reintegrate into society through activities formulated to increase their knowledge and skills, re-establish their ability to engage in work, and develop their self-esteem. A minority of countries rely on a third framework, that of multifunctional agriculture. This approach emphasizes the cyclical rhythm of nature, the structured and caring qualities inherent within farming activities, and the tradition of providing care on farms (Dessein, Bock, and de Krom, 2013: 55).

The farm communities often offer opportunities for community, companionship, work, creativity, respect for individual, provide structured and creative activities paired with psychotherapy and medication if needed, and may sometimes include the idea of spiritual rebirth. Activities may include animal-assisted therapy and/or activities to induce and mediate physiologically de-arousing states of anxiety and arousal, mediate social interaction, and provide stress-buffering social support; work-related activity to enhance self-efficacy and coping skills; art and/or other expressive therapies to help reduce feelings of isolation and increase self-confidence; spiritual programs, and physical activities, e.g. walking, activities of everyday living.

The farm communities meeting these definitions known to us in the USA include Gould Farm in Massachusetts (1913), Spring Lake Ranch in Vermont (1933), Rose Hill Center in Michigan (1991), Hopewell in Ohio (1996) and CooperRiis in North Carolina (2003).

Hopewell in Mesopotamia, Ohio, USA provides one example of a residential therapeutic farm community for adults with serious mental illness. Founded by Cleveland native, Clara Rankin, and a dedicated board, Hopewell accepted its first resident in 1996. Hopewell is one of a handful of therapeutic farm communities in the country and the only

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one of its kind in Ohio. Like the original therapeutic farm communities, Hopewell serves a relatively small number of individuals, no more than 40 adults at one time. The residents share housing in four residences. At any given time, Hopewell employs between 30-40 full time and part time clinical, direct care and administrative staff. Patient goals include self-care, psychiatric understanding and functioning, community participation, peer interaction, vocational goals and efforts, independent living, emotional regulation, spiritual integration, family life, and creative expression. Available services include mood management, dialectical behavior therapy (DBT), creative expression, attention to dual diagnosis issues, equine assisted learning, meditation and spirituality, education (high school diploma program), money management, independent living skills (planning, shopping, cooking, healthy living), family counseling, case coordination, psychiatric and medication management, and assistance with discharge transitions.

Fig. 1 – Two of the four cottages for Hopewell residents, Mesopotamia, Ohio

CooperRiis, Located in Asheville, North Carolina USA, provides another example of a therapeutic farm community. The recovery programming of the CooperRiis Healing Community embraces a holistic approach known as the "Seven Domains of Recovery" with the resident's experience guided both by their Dream Statement as well as by the challenges of their diagnosis. It seeks to provide the best of science within the healing milieu of the therapeutic community. In addition to the daily work and social/recreational activities of its structured community experience, CooperRiis offers individual psychotherapy, group therapy, family support and education, nutritional and wellness counseling, psycho-education, addictions counseling,

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neuro-enhancement activities such as neurofeedback and mindfulness training, yoga, Tai Chi massage therapy, along with ongoing psychiatric evaluation and medication optimization. All staff members are trained in the recovery process methods and facilitate each resident's recovery. Its therapeutic farm community serves 36 and its therapeutic urban community 24, while its 'Community Program' integrates residents into work, school and independent living through its 14 homes in and around Asheville. Overall, about 105 residents are served by 150+ staff.

Fig. 2 – Drumming at CooperRiis. Drumming provides an opportunity to be creative, to express one's emotions and to participate with others in creating music.

Since the mission of therapeutic farms today is to help return their residents to lifestyles within which they can sustain their highest levels of functioning and fulfillment, attention is also paid to successful re-engagement with families. For example, the CooperRiis Family Education Curriculum provides a mutual education process that can be applied to each individual and their family, in order to create a more powerful recovery partnership between family members and residents. Topics covered in the curriculum include: understanding emotional health conditions, strengthening communication skills, common reactions to emotional health conditions for both residents & family members, definitions of family, and problem solving. Alumni support and a respite program also give former residents ways to retain their sense of relationship with the often profound experience of having been a resident in a therapeutic community.

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Current Challenges to Therapeutic Farms

Current challenges to the continued existence of therapeutic farms fall generally into four categories: financial, legal, leadership, and political.

3.1 Financial Challenges

Care is relatively expensive. In the United States, health care is often paid for through health care insurance, but very often, health care insurance will limit how long an individual can stay in a facility or the amount of coverage available for residential mental health care. This means that an individual who needs a longer length of stay to become stable and recover must have their own funds or family funds that can pay for the care. Additionally, therapeutic communities are generally organized as nonprofit organizations and generate scholarship resources through donations.

In many countries, therapeutic farms are highly regulated. These regulations may relate to required staffing, required reporting about the residents' care, and/or the maintenance of the farm, the farm's employees, and the animals and produce. As a consequence, significant staff time is required to comply with the regulations and to document that compliance. A failure to do so can lead to expensive fines and serious sanctions.

3.2 Legal Challenges

The complex regulations often mean that a facility must obtain legal advice, which is also expensive. In addition, the facility could potentially be sued by a resident who believes that he or she was not treated well, or by the family of a resident, for example, if the resident commits suicide. (This can happen even if it is known that the mental illness might lead someone to commit suicide.) Even if the facility were to win the lawsuit, it would be expensive to defend against one. It appears that such lawsuits would be more likely to occur in the United States than in Europe.

3.3 Leadership Challenges

There is very little succession planning. If the director of a therapeutic farm community decides to retire or leave, there may not be anyone ready to assume his or her position. Additionally, because the

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regulatory, legal, and funding requirements are so complex, it is important that the director be able to advocate for the facility and for therapeutic farm communities in general. It may be difficult to identify and hire such persons.

3.4 Political Challenges

Politicians may not see the need for this type of care, erroneously believing that all individuals can receive adequate treatment by sitting in the office of a counselor or by taking medication. They may mistakenly believe that it is impossible for individuals to recover from mental illness, that individuals with mental illness are likely to commit violence against others and should therefore be forced to take medication, and that this type of care is too expensive and not worth the cost. Many people, including politicians, may believe that "one size fits all" in treating mental illness, whether that one size is medication, hospitalization, isolation from the community, a specific diet or dietary supplement, or genetic engineering. Again, it takes strong leadership to convince politicians otherwise and to advocate successfully in this kind of political environment.

Conclusion

Therapeutic farms offer an important alternative to individuals who are suffering from mental illness. With appropriate programming, staffing, and oversight, they can provide individualized care to persons who may be unable to live with their family members or in their communities and assist them to regain their mental and emotional balance, their capacity to form and maintain healthy relationships, and their ability to engage in productive work.

However, both in Europe and in the United States, these farms, whether referred to as therapeutic farms, green care farms, or care farms, often face formidable challenges to their own health. Their continued existence and future growth will depend on our ability to forge strategic coalitions and partnerships, always bearing in mind the foundational principles of moral treatment while remaining attuned and responsive to external threats.

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Biodata

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Virgil Stucker is the founding Chairman and President of the Foundation for Excellence in Mental Health Care and is the current and founding Executive Director and President of CooperRiis Healing Community. Previously, he had worked for 14 years at Gould Farm, America's oldest therapeutic community for individuals recovering from mental illness. He was also the founding Executive Director of Rose Hill in Michigan which opened in 1992 and of Gateway Homes of Richmond, Virginia which opened in 1986. He was the founding Program Director of Gould Farm's Boston Program, the past founding president of the REACH Community Health Foundation, Vice President of Planning and Development for Northern Berkshire Health Systems, President of the Berkshire Taconic Community Foundation, and Adjunct Professor of Philanthropy for the Visionaries Institute of Suffolk University. His holds a MBA with a focus on non-profit creation and management and a BA in philosophy. He graduated Phi Beta Kappa.

Richard R. Karges (Rick) serves as the Executive Director/Chief Executive Officer (CEO) of Hopewell, a therapeutic farm community serving adults with mental illness He was previously with Crisis & Counseling Centers, a community behavioral health center located in Augusta, Maine, where he was CEO for seven years. He received both his BS and MSW degrees from The Ohio State University and completed training at the US Army Academy of Health Sciences. Rick was recognized for his outstanding work in the mental health field when he was named the 2007 Professional of the Year by the Maine Chapter of the National Alliance on Mental Illness (NAMI). He has served as Chair of the (Maine) Governors Substance Abuse Services Commission and has been an adjunct Social Work instructor at Ohio State University and Case Western Reserve University. He has contributed to various professional journals addressing mental health issues and practice areas.

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