FAMILY CARE OF MENTAL PATIENTS

A Review of Systems of Family Care in America and Europe

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PART I. FAMILY CARE IN AMERICA

CHAPTER I

*Introduction—Family Care of Mental Patients**

BY HORATIO M. POLLOCK

Systems and methods of care of mental patients have been discussed in this country for more than a century. For a long time progress was discouragingly slow. Cruel, heartless treatment gave way to humane custodial care only after long agitation and much misgiving. Such care was in turn superseded by scientific treatment only after another long period of discussion and trial. The modern hospital for the care of mental patients with its magnificent buildings, its trained personnel and elaborate medical equipment represents the culmination of the thought and effort of many decades. But the end is not yet. Science has entered the field and science is never satisfied. The scientific spirit spurs us on toward the discovery of new and better methods of medical treatment and of more economical and more efficient methods of care.

Necessity also has spurs and is beginning to use them. The ever-present conflict between what we want to do and what we are able to do is growing in intensity and is threatening the mental health

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of the nation. Taxpayers groan under present burdens and are insistently demanding relief. The problem now before those vested with the care of mental patients is that of maintaining scientific standards while reducing per capita costs.

Economic changes of recent years have wrought havoc in our social order. With the possibility and the prospect of a better civilization with higher standards of living before us, we have been compelled to witness the decline of a large part of our population to a condition of idleness and poverty. Modern machines enable us to produce much more than we can consume. From such abundance we would naturally expect bountiful living and a general advance in health, education, science and art. Unfortunately, just the opposite result is being experienced. Markets are flooded with products, labor is poorly employed. Income from securities is small. Rigid economy must be practiced by a large part of the population. New ways of making a living must be sought. Greater utilization of home resources for employment and means of income are everywhere receiving consideration. Hardest hit are the village and rural communities that have lost their industries. Some of these communities are reenacting the story so beautifully told in Goldsmith's "Deserted Village." In the presence of these conditions it seems probable that many families in such communities would welcome the opportunity of rendering humanitarian service to the state by caring for mental patients for reasonable compensation.

Looking more closely into the present status of the care of mental patients in this country we find that about 400,000 patients with mental disease are being cared for in institutions. Of these, about 340,000 are in state hospitals and about 60,000 in other institutions. The present annual rate of increase of patients in state hospitals is about 4½ per cent. With this rate compounded for 50 years we can easily compute the institutional load our grandchildren would have to carry. Unfortunately, the increase of mental patients is cumulative and the annual rate is increasing. While we are waiting and hoping for a change of trend it behooves us to make provision for the inevitable increase of the next few years.

If mental patients were the only dependents to be cared for by the state the matter would be comparatively simple; but the resources of public treasuries have already proved inadequate to meet the demands made upon them. Even our wealthier states have been obliged to float large bond issues for public relief and for the erection of new buildings for mental patients and other classes of dependents. Naturally there arises the question as to whether new ways and means of lessening the burden of dependency cannot be devised.

To provide for the increase of mental patients we must either build new hospitals or make ar-

rangements for the care of part of the patients outside of hospitals. The problem we are facing is similar to that which has obtained in Germany ever since the World War. In that country means have not been available for the construction of many new hospitals. Hospital care has therefore been supplemented by placing patients in families for small compensation or by keeping patients under supervision in their own homes. This system of family care adopted by necessity is found to be giving a high degree of satisfaction. The patients receive adequate care and the families caring for them are thereby placed in a better economic position.

The question of organization of systems of family care to supplement institution care is being seriously considered in this country. It is probable that in the near future several states will join Massachusetts and New York in using family care for at least a small number of selected patients.

To aid us in determining what kind of family care is best, we have many examples before us. It is well known that at the famous colony at Gheel in Belgium mental patients have been successfully cared for in homes of both villagers and farmers for several centuries; that Scotland has placed patients in isolated families for 80 years or more; that France, Sweden and Switzerland use family care for a part of their mental patients; that Massachusetts, since 1885, has conducted family care of patients on a small scale; and that in nearly every state of this country unrecovered mental patients are placed on parole either with their own relatives or with other families. There is, therefore, no question about the feasibility or desirability of certain types of family care.

In introducing a system of family care consideration must be given to the welfare of patients, the expense involved, the means to be taken to secure adequate supervision, the conditions to be met to obtain public approval and the general welfare of the community in which the patients are placed. The system in use in Scotland by which the insane are cared for in widely separated homes has, on the whole, little to commend it to Americans. It may be economical and it is possible that the patients as a whole may be well cared for, but proper supervision of such care cannot be exercised and the system seems ill-adapted for large scale placement. The system developed by Dr. Kolb at Erlangen, Germany, by which patients in homes are kept under the immediate supervision of the state hospital seems better than the Scottish system but does not seem adapted for extensive use in this country. The system at Gheel though far from ideal presents many features which could be adopted with suitable modifications in the organization of systems of family care in this country.*

*See Chapters VII, VIII and IX.

In the light of the experience thus far gained it would seem feasible to attempt the establishment of special colonies of the Gheel type in selected country villages in this country. The colony of the sort I am visualizing would have a central community house with emergency hospital facilities for a few patients. This community house would be the headquarters of the physician in charge of the colony and of the social workers, nurses, occupational therapists, and others who would supervise the patients placed in family care. The community house would serve as an intermediate station between the state hospital and the families receiving patients. Patients would go from the state hospital to the community house and from there to their family home. If it became necessary to return a patient placed in family care, he would be sent first to the community house and then either to another family or back to the state hospital. The community house would also serve as a social center for the patients of the colony.

The number of patients that could be economically placed by a single center would depend on several factors including the willingness of the people residing in the community to receive patients, the number of available families and the number of available patients. In some village communities it is probable that 1,000 patients might be placed without great difficulty. With others the number might be as low as 100 or 200. The system would

necessarily start with small beginnings and would develop gradually until a large group was reached.

A colony might be started by placing a certain number of patients directly from the hospital and later establishing a community house, or a community house might first be established and patients placed out from such house as rapidly as found expedient. If the project were undertaken it should be preceded by active propaganda showing the benefits to be derived from family care, the opportunities offered to families to render humanitarian service and the advantage to be derived by the state and the community from the introduction of the system.

In beginning a state system of family care it might be expedient to start with the placing of mental defectives as Dr. Charles L. Vaux of the Newark State School is doing in the village of Walworth, N. Y.* It is believed that mental defectives might be more easily placed than mentally diseased patients and would not be quite so difficult to manage. If a colony were started and developed into a large undertaking such as here projected it would serve as an example to other communities and the success attending the first colony would aid greatly in the establishment of other colonies.

Good judgment must be exercised in selecting patients for family care. In a mental hospital, patients suitable for placing out include quiet schizo-

*See Chapter III.

phrenic cases, chronic manic-depressives, and other undisturbed types that are tractable and capable of following instructions. These, in some hospitals, would include a third of all resident patients.

Types not suitable for family care include the following:

1. Patients with acute disorders who are likely to recover within a few months.
2. Patients that are noisy, destructive, violent or suicidal.
3. Patients that are bedridden or that require constant medical and nursing care.
4. Patients that are undergoing special medical or psychiatric treatment.
5. Patients that are contentious or have pronounced delusions of persecution.
6. Patients with marked erotic tendencies.
7. Patients that have severe convulsions.

The care of infirm patients in private homes would be possible only if special facilities were provided. It is probable that if standards of care were not made too high many families might desire to establish nursing homes for infirm patients. In these homes the state hospitals might place patients whose relatives would be willing to pay $10 to $15 per week for their care but could not afford the higher rates charged by well-equipped licensed institutions. It is, of course, conceivable that a

nursing home might be a large institution rather than a family affair. However, I see no good reason why a family having a spacious home could not use it for a nursing home to accommodate as few as five or six patients. Already many such nursing homes are in use for the care of the infirm and neurotic who are not classed as psychotic. If state encouragement were given these homes their number would multiply and the state hospitals would be correspondingly relieved.

The financial side of family care deserves most careful consideration. It is probable that the rate to be paid for the board of patients should not be uniform. Women patients who are able and willing to help with housework and men patients who would render service in the garden or on the farm would be placed at a much cheaper rate than patients who are unable to work. Patients requiring a great deal of personal supervision should be paid for at a higher rate than those able to care for themselves.

In general, family care should be much less costly than hospital care. The latter varies widely in different parts of the country. In northern states providing good medical and nursing service in well-equipped hospitals, the per capita cost of care of mental patients amounts to nearly $12 per week. This amount includes cost of housing and administration as well as cost of maintenance. Housing cost alone in the newer hospitals amounts

to approximately $5 per week. If a system of family care were instituted it seems probable that the housing charge could be saved and the entire expense of maintaining patients in family care could be defrayed by a total per capita expenditure of from $5 to $7 per week. At this rate a substantial saving would result.

The advantages derived from family care are four-fold: Patients placed in suitable families resume a measure of community life with a natural environment and with more freedom than could be possible in a state hospital. The families receiving patients have an outlet for their altruistic sentiments and acquire a secure economic status. The state hospital relieved of many of its custodial cases can devote more of its energies to the scientific treatment of acute and recoverable patients. The state conducting an extensive system of family care would be relieved of the necessity of building new hospitals and would have a better opportunity to treat its mental patients in accordance with their individual needs.