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The Therapeutic Farm Community: An Innovative Intervention for Mental Illness

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Abstract

Romania is currently making efforts to deinstitutionalize residents of its mental health hospitals and initiate a system of community-based mental health care. To be successful, the system of community-based mental health care must include a network of caring and responsible people who are committed to helping those who are mentally ill meet their needs while reintegrating into and remaining a part of the community. Therapeutic farm communities (TFC), or care farms (CF) as they are known in Europe, can serve as a critical component in efforts to assist mentally ill individuals regain their stability and independence. TFCs, which often focus on individuals diagnosed with schizophrenia, bipolar disorder, and major depression, promote self-sufficiency through their therapeutic use of farming-related activities, including organic farming and animal care. In addition to farm maintenance activities, programming may include mood management, dialectical behavior therapy, creative expression, equine assisted learning, meditation, education, money management training, and independent living skills activities (planning, shopping, cooking, healthy living), and medication management. This paper first reviews the use of TFCs in Europe and the US, focusing on Hopewell as a model for the US TFCs, and examines the suitability and sustainability of the TFC/CF model for mentally ill persons in Romania in the context of Romania's current political and economic climate.

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Keywords: Mental illness; therapeutic farms; care farms; deinstitutionalization

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1. Romania's mental health care system

In April 2000, Romania disbanded the system of national health care that had been established under the Ceauşescu regime in favor of an employment-based insurance approach. The newly implemented system of care has not lived up to the promise of universal, accessible health care. Instead, individuals who are unemployed or underemployed continue to face problems of access to care. There have been well-publicized shortages of medications, food and cleaning supplies in nursing homes, orphanages, and psychiatric hospitals. Institutional staff members have staged walkouts in response to the government's failure to pay wages. Romania continues to face a drastic shortage of trained mental health professionals and mental health researchers. And, even though Orthodox clergy often provide mental health counsel to the faith's adherents, they often do so without having had adequate training to diagnose or treat either mental illness or substance use.

It is in this environment that Romania seeks to deinstitutionalize psychiatric patients, many of whom may have been residing in psychiatric hospitals for lengthy periods of time. In order to do so, Romania must replace these long-stay hospitals that have been the country's primary mode of treatment "with smaller, less isolated community-based alternatives for the care of mentally ill people" (Lamb & Bachrach, 2001). This will require that efforts be made to (1) prevent inappropriate mental hospital admissions through the provision of community alternatives for treatment, (2) release to the community all institutional patients who have been given adequate preparation for such a change, and (3) establish and maintain community support systems for noninstitutionalized persons receiving mental health services in the community (Bachrach, 1977). These requirements for effective deinstitutionalization raise the issue of where institutionalized persons can receive their care.

The plight of Romania's mentally ill residents has not gone unnoticed. The World Health Organization found that as of 2004, Romania's National Mental Health Programme of 1999 continued to be inadequately funded. Romania spends only 4% of its GDP on health and only 3% of that 4% is specifically allocated to mental health treatment (South-Eastern Europe Mental Health Project, 2004). The 2004 Mental Health Policy imposes significantly greater benchmarks for the care of the country's mentally ill, requiring (1) the development of training programs in mental health for medical school students, psychiatrists, psychologists, nurses, social workers, and mental health professionals; (2) the development of mechanisms to attract other specialists into the mental health field, including psychologists, sociologists, and lawyers; (3) the introduction of mental health issues into the syllabus of medical schools; and (4) the establishment of a Mental Health Research Institute in collaboration with the National Academy of Medical Sciences. Additionally, the Policy calls for the use of both quantitative and qualitative methodologies, epidemiologic analyses, and organization assessments to assess community attitudes, identify the service needs of mentally ill persons and their families, identify the mental health training needs of professionals across a wide range of disciplines, and evaluate existing mental health treatment approaches, services, and the institutions responsible for their delivery.

Accordingly, these circumstances raise the question: How can Romania meet the imperative to deinstitutionalize individuals with mental illness and provide community-based care, given the fiscal constraints that now confront the country?

2. Care farms: A potential mechanism for recovery from mental illness

2.1. The care farm in Europe

The term "care farm" has been used in Europe to refer to the use of commercial farms and agricultural landscapes for the promotion of human health, social inclusion, and educational benefits through farm activity (Berget & Braastad, 2011). The numbers of such farms in Europe is steadily growing. It has been estimated that as of 2005, there were 591 care farms in the Netherlands, 250 in Austria, between 30 and 350 in Italy, and 76 in the United Kingdom (Di Iacovo, Senni, & De Kneght, 2006; Hassink & van Dijk, 2006). The care farms may be intended to serve any of multiple purposes, including the effectuation of an increase in the health, well-being, and integration of diverse patient groups, e.g., persons with mental illness, dementia, or substance use disorders; the reduction of health care costs; and the maximization of farm production (De Bruin, Oosting, Kuin, Hoefnagels, Blauw, De Groot, et al., 2009; Hassink, Zwartbol, Agricola, Elings, & Thissen, 2007). The variety of names used to refer to these