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Nonemergency Forensic Psychiatric House Calls

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ABSTRACT: Recent literature on medical house calls in general is not extensive, and that on nonemergency forensic psychiatric calls in particular is nearly nonexistent. Two cases of nonemergency forensic psychiatric house calls are described in this communication; it is our contention that they led the psychiatrist to a better appraisal of the person's capacity to perform than would have been expected from office visits. One situation involved testamentary capacity; the other, possible abrogation of parental rights. In our estimation the individual, as well as the legal system, would benefit if this type of house call were promoted.

KEYWORDS: psychiatry, medical house calls, parent child relations, nonemergency, testamentary capacity, parental rights

"Firefighters still make house calls," reads a bumper sticker seen recently in the Bronx. The irony of this statement aside, an unspoken anger and resentment are directed at those who traditionally made house calls and lately have done so less and less. House calls historically were an important part of a physician's work, but have become increasingly rare.

Review of the Literature

A review of the literature of the past ten years reveals very few articles on psychiatric house calls [*1-3*], and none specifically on forensic psychiatric house calls. In fact the entire field of medical house calls is the subject of no more than a dozen communications each year [*4-17*]. For the most part these have pertained to the demographics of house calls [*4*], the use of house calls for pediatric and geriatric purposes [*2,3,5*], and the house call as studied in various particular communities [*6*] or experienced by groups of physicians [*7,8*].

While the above references are not directly related to our subject, it is worthwhile to examine some of them briefly. Several authors have noted a trend towards renewed interest in and use of house calls [*4-9*], including psychiatric house calls. It is in part this shift that prompted our report of the present cases.

Analysis of the cost of house calls versus other current methods of physician care, mainly office practice, shows that house calls compare favorably. There is a need for basic research on the cost-effectiveness of house calls and for specialty training of house staff [*16*].

The specific usefulness of the psychiatric house call has been demonstrated in reports of the treatment of children [*3*], the elderly, and families whose complex systems render a perspec-

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tive of their home environment especially enlightening [*1,2*]. Recently, added support for the place of house calls in American primary care has come from an article that analyzes house calls by type and stresses the ways in which the training environment of family practice can foster the increased use of house calls [*9*]. The types of house calls listed are the emergency house call, the acute illness house call, the chronic illness house call, the dying patient house call, the house call to pronounce death, the grief house call, the home management versus hospitalization house call, and the home visit house call. As none of these types encompasses the situations presented by our cases, we propose that an additional type be added, the nonemergency forensic psychiatric house call.

Case Summaries

Case 1

Ms. L is an 85-year-old single retired bank secretary who lived for many years in an apartment with her single brother. After his death she continued to live in the apartment alone, occasionally tended by a younger married brother, but managing most of her affairs and housekeeping chores alone.

We were asked to evaluate Ms. L by her attorney. It appeared that some younger family members were concerned about Ms. L's mental capacities and had started to suggest rather forcibly that she move to a nursing home and give them control of her quite comfortable estate. Ms. L had vigorously objected to this and in fact decided to rewrite her will, disinheriting these relatives. She spoke with her attorney, who had long served the family; he concurred with her plan. Nonetheless, prudently and with foresight, he felt that a psychiatric evaluation for "testamentary capacity" would be a safeguard for the future, should the younger relatives decide to contest the will after Ms. L's demise.

Our evaluation of Ms. L was conducted in her home and was more valuable and conclusive because of this. Her mental status examination was quite unremarkable, save for a mild to moderate memory deficit, which increased slightly with stress. We conjectured that had she been seen in the unfamiliar and anxiety-provoking setting of an office she might have performed more poorly. In such a case, without a firsthand view of her neat apartment, which clearly attested to her ability to manage her daily life, we would have had to equivocate in the report, rendering the document less useful to Ms. L and her attorney.

Case 2

Mr. F is a 45-year-old separated father of two girls, ages 5 and 8, who lived in an apartment with his girlfriend and had not left home for 1½ years. The court asked for an evaluation because the social agency involved with the foster care of the children was seeking termination of parental rights to enable the preadoptive parents to proceed with adoption.

The case was complex, and also rather atypical. Ms. F, the estranged wife of Mr. F and mother of the two children, had been a resident of a psychiatric hospital for a number of years and was unable to care for herself or her daughters. Mr. F was a recovered alcoholic who had functioned at work in a fairly adequate fashion until about two years before he was seen by one of us, at which time he began to have panic attacks and ceased leaving his apartment. Because of his agoraphobia he was unable to appear in court, and thus the judge ordered that an evaluation be performed in the home. After this examination Mr. F was found to be unable to care for the children and it was recommended that they be adopted.

At first the unusual aspects of this case make it seem too special to be an example from which to generalize about other family court problems. Yet, we saw the obvious benefit from the house call to all the people involved, irrespective of Mr. F's agoraphobia. By examining Mr. F in his own setting we were more readily able to assess his caretaking abilities. The

trauma of being removed from his apartment would have been extreme for Mr. F, but even for a parent without agoraphobia, there would be stress involved in an interview outside the home, perhaps to the degree that an accurate picture of the situation would be difficult to obtain. A house call in this type of case allows the psychiatrist firsthand evidence, and access to information not to be found in any other way.

Discussion

A survey of recent literature indicates a mild but growing trend toward reviving general medical house calls, as shown by a certain interest in the inclusion of pertinent training in residency programs and in efforts to systematize and define current types of house calls. Despite this, there has been a neglect of the use of house calls in psychiatry, as well as in forensic psychiatry, evidenced by an absence of publications. This neglect may in part be related to various negative considerations for the psychiatrist, particularly the potential lack of cost-efficiency, personal danger, and possible charges of unethical behavior. These practical considerations must be dealt with in connection with house calls.

Home visits are the traditional sector of the health district nurse and the social worker, both being specifically trained for the purpose. However, home visits by these professionals are not equivalent to house calls by the physician-psychiatrist: the former evaluate the home and family in their impact on the patient's well-being, while the latter attempt to diagnose a disease. Diagnosis of disease is the responsibility of the physician and requires personal examination.

Special skills are required for making house calls. While there are continuing training programs for physicians [*16,18*], it is recognized that medical schools should develop such training to a larger degree.

The question of personal risk incurred in the course of carrying out a house call cannot be dismissed lightly [*19*]. In the case of a court-ordered psychiatric house call it is incumbent on the court to supply protection; if the house call is made at the request of the patient or the patient's attorney, any arrangements for protection must be made by them. In most instances it would seem appropriate to make psychiatric house calls accompanied by a social worker.

Financing the increased cost of a house call compared with the cost of an office visit may create an additional burden; public and private medical insurances should be persuaded to share part of the cost.

Although realizing the validity of the foregoing practical considerations, our experience has led us to try to promote the use of house calls in connection with certain forensic psychiatric problems that are not emergencies, as well as to propose an additional category to those previously reported [*9*], namely the nonemergency forensic psychiatric house call.

Our cases demonstrated the use of the house call for evaluative purposes of quite different questions. In both cases, the problem was best elucidated in the natural environment of the individual. In both, the time involved for the psychiatrist was probably more than usual, yet this was offset by the greater degree of clarity and certainty obtained. No time needed to be spent speculating how the house looked or how the person might have performed at home. The psychiatrist did not need to rely on a case worker's report of a home, but saw it directly. Finally, certainly in both cases the experience was less adverse for the person being evaluated.

The usefulness of house calls in cases of testamentary capacity and family problems is fairly clear, but we wondered if a more creative definition of "house calls" might not be used to include criminal forensic psychiatric work. It has been suggested that for criminal evaluations, for example in instances invoking the insanity defense, "house calls" can be crucially important.[3] House calls in this sense might include visits to a defendant's home, hotel, family,

[3]Park E. Dietz, Law School, University of Virginia, Charlottesville, VA, personal communication, 1982.

school, or work place. They might include visits to the scene of an alleged crime. For dispositional suggestions, they might include visits to a facility, hospital, or home where the defendant might be sent if found guilty or ill. Through this type of work, the psychiatrist is more able to assess the defendant, the influences upon him or her, and possibly future influences. Given the often serious nature of the crimes involved and the serious consequences for the defendants, the time and expense involved are mitigated by the additional information garnered in the service of justice.

Conclusion

Two cases of psychiatric house calls, one ordered by the court and the other requested by a private attorney, are described; as these house visits did not fit into any previously established category, we propose a new one, the nonemergency forensic psychiatric house call. We conclude that the use of house calls in certain forensic psychiatric cases will better serve the interests of the individual and, on a larger scale, those of society. House calls might, in addition, remind the medical profession that forensic psychiatrists are physicians above all else, not just extensions of the arm of the law.

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