*Mental After-Care.* By HENRY RAYNER, M.D.Aberd.

MENTAL after-care, since the establishment of the Association bearing this name more than forty years ago by Mr. Hawkins the then Chaplain of Colney Hatch, has become very generally adopted in most countries.

The English Mental After-Care Association at first only dealt with women discharged recovered from asylums, but after some years men were included; still later those recovered under any form of treatment, whether in mental hospitals, Poor Law infirmaries, out-patient departments or mental clinics, etc. The care has been extended also to patients discharged on probation from mental hospitals, and a still later extension has been the making of a preliminary inquiry of the home conditions to which the patient would be going on discharge, for the information of the mental hospital authorities, the report being accompanied by suggestions in regard to the form of assistance that would be needed. In these various ways the discharge of patients has been greatly facilitated and probably hastened in many cases, whilst the danger of relapse has been very greatly reduced.

The Association had at the outset much to learn in regard to the best means of providing convalescent care, and in the modes of finding occupation and suitable employers, all of which has now become comparatively simple and routine.

In the earlier stages the help was confined to finding one suitable situation, but it was soon found that some needed more than one start in work, and now many of those helped return again and again over periods of years for sympathy, advice and help when threatened with relapse, such relapses often being avoided by obtaining medical advice or temporary convalescent-home care, sometimes provided by friends, employers, or at times from the patient's own means.

The help thus afforded has without doubt been very efficacious in preventing relapse and in conducing to the comfort and happiness of those assisted; but it by no means exhausts the possibilities of after-care, which indeed may still be considered as being in an early stage of its usefulness.

The discharges from mental hospitals are recovered mentally, but it by no means follows that they are in good bodily health or that they have been cured of habits of life, tendencies to disease or actual bodily defects or diseases, which in conjunction with mental conditions had produced the original breakdown.

The careful and thorough examination of patients in mental

https://doi.org/10.1192/bjp.70.290.358 Published online by Cambridge University Press

hospitals discovers these causes of disorder, and the physicians must often regret that owing to the mental recovery they are debarred from prolonging the advice and treatment that would ensure a thorough cure, or at least a prolonged freedom from the danger of a recurrence. This affords an opportunity for an extension of after-care which might be met by the provision of after-care helpers to whom the patients might apply, and who, on the instruction of the mental hospital physicians, might ensure that the patients, when wishful to do so, obtained the advice and guidance of the physicians who had had such full opportunities of studying their cases. This would establish a continuity of the mental hospital advice and treatment that should have very beneficial results, especially in cases tending to frequent relapse.

This extension of the work would, of course, necessitate that the association workers should obtain some knowledge of mental disease and disorders by a special course of instruction that would fit them for giving this form of assistance. This instruction the mental hospital physicians would assuredly provide.

Mental after-care, taken in its widest sense, should include help to *all persons discharged under any conditions* from mental hospitals or who needed assistance after having been under *any form of treatment for mental disorder* elsewhere.

This would embrace many forms of assistance that the Mental After-Care Association, owing to paucity of funds, has been hitherto unable to undertake.

Epileptics, for example, cannot be helped, since they would require to be cared for in a home with opportunities of outdoor employment, such as is provided by epileptic colonies (from which mental cases are excluded). To cover the needs of the whole country probably several small homes, in appropriate situations, would be needed to effectively aid this class.

Alcoholic cases have not been helped hitherto, and as inebriate homes exclude mental cases, provision similar in character and extent to that needed for epileptics would be needed for this class. Both of these classes, in the absence of after-care, lose much of the benefit derived from their treatment.

Aged persons, recovered from their mental trouble but unfit for occupation, have been unaided by the Association, and their only resource, where they have no friends, is a life in the workhouse. This, in a certain proportion of cases, is a hardship which it would be desirable to avoid if suitable homes could be provided. Many would have old-age pensions.

After-care is needed for the large number of mental cases under the Ministry of Pensions, and this, if means were forthcoming,

https://doi.org/10.1192/bjp.70.290.358 Published online by Cambridge University Press

should be an additional opportunity of usefulness. The Ministry of Pensions is desirous that such help should be provided, and if the After-Care Association could find the necessary funds its help would almost certainly be made use of.

The "boarding-out" of partly recovered cases might be greatly extended in England, I believe, by the After-Care Association, aiding in finding suitable homes and hosts for such cases, who when so placed would be monetarily provided for and supervised by the Poor Law Authorities under the inspection of the Board of Control as at present provided.

In Scotland a large proportion of the insane has been "boarded out" for many years past, and this has been carried out in Germany to a large extent, even in large towns, such as Berlin.

There can be no doubt that a similar proportion of cases fit to be boarded out exists in English as in Scottish mental hospitals, and the only obstacle has been the provision of suitable conditions for them.

In Scotland the provision has been made by the Poor Law, the supervision being carried out by Poor Law doctors and officials, supervised by Lunacy Board officials, and this has worked satisfactorily.

It is, however, possible that if the Poor Law provision was assisted by the aid of a voluntary benevolent association, with appropriately trained helpers, the system might work even more satisfactorily, that boarding-out difficulties might be more readily overcome and the system largely extended.

In this way a great number of partially recovered patients, now condemned to an institutional life, would not only have a greater enjoyment of existence, but, if the Scottish experience can be relied on, a greater hope of ultimate recovery. Many of them, under suitable supervision, might find occupation that might be equivalent to some part of their maintenance, and this, in any case, would be less than that in an institution, while the mental hospitals might be relieved of some thousands of cases.

Mental after-care has been so fully recognized as an absolute necessity in the provision for mental diseases that there can be no doubt that the means of providing it will in time be forthcoming. The facts that *the King has made a handsome contribution to the funds of the Association*, and that *the Prince of Wales has become its Patron*, are a sufficient evidence of the success and necessity of the work.

The committees of the county and borough asylums possess the power of contributing to mental after-care funds, and the boards of guardians can do the same, although in both instances the power as yet has not been extensively employed.

https://doi.org/10.1192/bjp.70.290.358 Published online by Cambridge University Press

The ideal organization of after-care would be the establishment of local committees in connection with each large mental hospital or in each smaller county, with larger divisional associations in the chief centres of population, these latter being especially in relation with the Divisions of the Medico-Psychological Association.

It has to be borne in mind that a great and largely increasing number of cases of uncertified mental disease are now being treated in the out-patient clinics of the general hospitals and asylums, in infirmaries and other homes. These are most numerous in the large centres of population, such as London, Manchester, Liverpool, etc., and since the funds of the county and borough asylums would not be available for such patients, the monetary provision for dealing with these could not be raised by the small local branches, and must come from the charitable efforts of these large centres. It is also to these divisional branches, with their larger opportunities for collection of funds, that the help must come, in great measure, for the establishment of homes for epileptics, alcoholics, etc., if ever these become possible. These must depend for their supervision and management on the larger centres, even if monetary aid was obtained from the Government. Such forms of after-care could not be undertaken by small local branches, although patients coming from all the branches in the Division would need to send patients to them.

The local mental after-care branches would be largely supported by the contributions from the local mental hospital committees and boards of guardians, as well as by collections in the hospitals and private donations for the purpose of after-care. This would necessitate a very careful report of their expenditure to assure the public and contributing bodies that the money had been expended solely for after-care purposes, and the committee expending such funds should be termed an "after-care committee," however closely it might be allied with the local committees for dealing with Mental Welfare.

An inquiry addressed recently to the medical superintendents and committees of mental hospitals shows that some are desirous of avoiding such Association, but that others are willing to do so. In some localities after-care committees are already in full work, being affiliated with the Central Association, and in a few instances the report is made that the conditions in the locality are such as not at present to demand a committee.

It is possible, as has been found by past experience, that committees cannot be formed in some districts, or, having been formed, become unable to work satisfactorily. In such cases the nearest divisional branch would probably undertake the work.

https://doi.org/10.1192/bjp.70.290.358 Published online by Cambridge University Press

This sketch of mental after-care organization appears to the writer, after more than thirty years' official experience, to be necessary to carry out thoroughly its share in the progress of mental hygiene in England and Wales.

---

*Moral Imbecility.* By IAN D. SUTTIE, M.B., F.R.F.P.&S.Glasg., Medical Superintendent, C.L.D., H.M. Prison, Perth.

THERE is a type of social psychology which finds the explanation of man's social behaviour in a hypothetical "disposition" of his mind. This motive-complex is conceived as specialized for the function of adapting conduct to social life, and as being in itself relatively closely integrated, developing and functioning as a whole. Of this hypothetical "gregarious instinct" McDougall goes so far as to say: "For it is highly probable that instinctive dispositions are Mendelian units" (*Journ of Abn. Psych. and Soc. Psych.*, vol. xvi, p. 316). This plainly suggests that the *unity* of the social disposition (its existence as a discrete factor in development) is to be regarded as antedating experience—that it is an ultimate datum for psychology not susceptible to analysis, and is *not* a derivative of any other known motive such as "love," "fear," or "hope of reward." This "instinct" interpretation of social behaviour has been criticized on many grounds (as unfruitful for psychology and incompatible with biological fact); but of course the demonstration of a Mendelian transmission of the social disposition would compel us to regard it as an *element* of character. Our conception of mental development and of the "socialization" of the individual, of the relative significance of upbringing as compared with organic endowment and our whole psycho-pathology depend upon our acceptance or rejection of McDougall's view. If he is right in regard to the germinal "unit" determination of the social disposition, criminological studies should offer verification. I propose, therefore, to consider how far we are justified in regarding moral insanity and moral imbecility as true "morbid entities."

Our problem may be roughly stated: How far is the social disposition of man a "unitary character," relatively integrated within the larger whole of the organism, and relatively independent of similarly integrated "impulse-bundles"? How far does it function as a discrete factor in development and in behaviour? If we are able to demonstrate pathological disintegrations selectively affecting social behaviour; if we find gross congenital defect of this function uncorrelated with defect in any other; above all,

https://doi.org/10.1192/bjp.70.290.358 Published online by Cambridge University Press