"AFTER-CARE" AND OTHER ASPECTS OF SOCIAL SERVICE AS AN ADJUNCT TO MENTAL TREATMENT.*

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ALTHOUGH the subject of my short address is named on the agenda "After Care," I am privileged by your chairman to touch upon the activities of social workers generally in regard to the welfare of the mentally afflicted.

As a preliminary there are four things I should like to say:

1. My remarks deal with the subject in respect only of the classes needing public assistance, and not with the well-to-do.

2. My views generally on the prophylactic approach to the problem of the mentally afflicted may be well known to my medical colleagues present, but perhaps not to the lay members of local authorities, though I did recently circulate among them copies of a small work in a blue cover which dealt with this subject. Men absorbed in public affairs have little time to study such publications, and only a few may have done so in this case. So my remarks are mainly addressed to them.

3. The views I express may not be those of the London County Council.

4. I shall use the words "psychiatry" and "psychiatric" a good deal—words covering a number of activities, all of which are directed towards the prevention, amelioration and cure of mental disabilities and disorders. One of these, the social approach to the solution of these problems, is the object of my discourse to-day.

Now the first point I want to make is that "After-Care" is also an important prophylactic measure, for a recurrence of mental disorder is often precipitated by a return to unsuitable homes and conditions of life.

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As I shall point out later, the welfare of cases (discharged from institutional care) at the conclusion of special after-care treatment should be in the hands of social workers and health visitors, all of whom I hope will soon have had sufficient psychiatric training in recognizing the early signs of mental breakdown and know what to do under the circumstances. As my time is short I had better make sure of dealing with the subject allotted to me on the agenda, which I take to be how best to carry out the provisions of the Mental Treatment Act in regard to after-care.

First of all, " What is After-Care? " It should at once be noted that modern " after-care " is a definite part of clinical psychiatry. It has progressed to this position from being originally a purely humanitarian and benevolent activity. Such motives lay behind the Bequest of one Joseph Harrison in 1825, in respect of after-care of patients discharged from Wakefield Mental Hospital, and which was the first of its kind. The same motives actuated Sir William Ellis, of Hanwell, in the part he played in the foundation of the Queen Adelaide Fund in 1836 for the benefit of discharged patients in London and Middlesex.

Clinical and prophylactic notions in after-care took root on the foundation, on June 5, 1879, of the Mental After-Care Association for Female Patients in the drawing-room of Dr. J. C. Bucknill, at 39, Wimpole Street, London. Without detriment to the humane and benevolent aspects, after-care was now urged as a means of preventing relapses. To the finding of suitable homes and occupations for women derelicts from mental institutions was added the conception of after-care treatment in special convalescent homes, some in the country, some by the seaside, a suggestion first made in 1871 by that great pioneer of after-care, the Rev. H. Hawkins, Chaplain to Colney Hatch Asylum.

Modern after-care envisages a great extension of this form of after-care work if the public and the local authorities can be so persuaded of its value as to give it their financial support.

The idea is that the rehabilitation and industrial training, the teaching of new occupations, the remoulding of character and the consolidation of the shattered personality, all begun in the mental hospital, are more likely to be brought to a successful issue in homes specially designed, equipped, administered and situated for these purposes, thus freeing beds in the mental hospitals for new admissions and acute cases. The treatment of mental disorders would thereby be brought parallel with that of physical diseases.

To these homes could also be sent cases needing such treatment

who have come under observation for threatened mental disorder in mental in- and out-patient departments of general hospitals, but great care should be taken that potential suicides are not sent. We do not want any such setbacks at these homes. This is, as an actual fact, a recent activity (Fore-Care) of the present Mental After-Care Association. So much for institutional after-care work.

Now as to the social and environmental after-care work. It is necessary to differentiate between after-care work of this kind for which special training, knowledge and character are required, and later after-care of a general kind which, under my scheme, would become a part of the work of the more general social worker under public health, educational, public assistance committees and parallel work of voluntary associations, including those devoted to mental deficiency.

It is also necessary to differentiate between such professional after-care workers and mental hospital visitors and their assistants, some of whom should, of course, be fully trained in psychiatric social work.

The differentiation I refer to may thus be stated. The professional after-care worker faces a business proposition. She has to visualize a person whose outlook is towards a very different field to that of a person entering, or who has entered a mental institution.

Something more and different is required of her than sympathy, kindliness, tactfulness, a training in methods of inquiry as to the factors causing mental breakdown, and a thorough knowledge of mental hospital care and treatment, and of the types of mental disorder, for which work a different training and experience and even character qualities are required.

She must have a special knowledge of economic factors of life, a capacity both to persuade and to drive a bargain with employers of labour. Her line of inquiry is the kind of home, its cleanliness and healthiness, the character of the neighbourhood and neighbours, the question of domestic happiness or strife, the habits and earnings of the family and their suitability to take charge of a recently convalescent patient, and a host of other matters, all having for their objective the return of the patient to right surroundings. Her inquiries are pertinent, and her attitude that of one who requires things to be done. She must have business abilities of no mean order and an unusual supply of common-sense if her report is to be of real guidance to those proposing to discharge the patient.

Nothing but confusion can arise from expecting a person to undertake both these essentially different kinds of social work. For both special training is needed, but on different lines.

So the professional after-care worker, I suggest, must be differentiated from both the highly-trained psychiatric social worker, and all other social workers in the general field of public welfare. Now I am not speaking from mere book knowledge, or information gathered from reports, etc., but from actual experience at Horton, where it has been the practice, since 1925, to obtain an after-care environmental report from the Mental After-Care Association in every case proposed for discharge (with few exceptions), including discharges under Section 79, and those of private patients.

We were, I think, the first mental hospital to take full advantage of the Association's offer to do this work for the mental hospitals. We gladly accepted it because our experience for some years, before the offer was made, was that the Association did this work exceedingly well. It has continued to do so, and though I do not speak on behalf of the Sub-Committee of the Hospital, I may venture to say that the Sub-Committee would find itself seriously handicapped without such aid in considering patients for discharge, so much so that it literally now could not do without it.

As regards the help of hospital visitors and psychiatric social workers in respect of cases on admission, I could speak, if it were possible, with even more confidence. The beginning of this movement in this country was at Horton, where in 1922, the first hospital visitor was appointed, and the fact that the recent Royal Commission was emphatic in recommending it, showed that its members had had before them overwhelming evidence of its value and necessity. Again, I can say we could not do without this assistance.*

But with rare exceptions we keep these two kinds of social work strictly apart, and the hospital social workers hand the after-care needs of their patients to the After-Care Association on leaving hospital either for good or on trial.

There is also a further distinction. Much, if not practically all of the hospital social work is best done by independent and purely voluntary agencies. It is delicate work of a kind which has to combat preconceived notions and prejudices in the homes in regard to mental hospitals. This does not hold good to such an extent in regard to after-care work. Presumably such ignorance and

* This first hospital visitor was found for me by Miss Evelyn Fox and the movement which has spread from Horton as a training centre owes to Miss Fox a debt of gratitude for her assistance.

prejudice has been dissipated and the local authority is free to subsidize, or even themselves undertake after-care activities.

I now come directly to the carrying out of after-care work within the provisions of the Mental Treatment Act. Having regard to the general considerations I have put forward, my recommendations to the local authorities are as follows:

To regard after-care treatment as best centralized in a national organization which can concentrate on the development of the work throughout the land, can keep in touch with employers everywhere, establish and maintain a variety of convalescent institutions and homes conveniently situated so as to be available for the use of all local authorities, and also give adequate training and experience in case work to social workers whose abilities and character traits render them specially suitable for after-care work.

Following acceptance of this postulate, I think local authorities should:

1. Guarantee an appropriate sum to the After-Care Association, which would wholly or partly support a specially trained after-care worker in the district. The latter would recruit and cooperate with voluntary after-care workers in the same district and act as *liaison* officer between the After-Care Association and all local bodies willing to assist.

2. Make full use of the After-Care Association's institutions wherever they are situated, and encourage the Association to build more and increase their variety to meet the needs of different types of patients. Some institutions should be devoted specially to rehabilitation and training, etc., and such other purposes as I have already mentioned. Local authorities should pay the full maintenance charges of these institutions for each of their patients when so accommodated. There is no legal obstacle to this now.

3. Make an annual *per capita* grant to the Association for the next ten years in respect of each patient so accommodated, to be expended solely on institutional developments, the amount of the grant to be a sum mutually agreed upon by the local authorities and the Association, and to be reassessed at the end of that period.

4. Local authorities, in virtue of this (3), could reasonably claim to be represented on the Council of the After-Care Association.

To avoid the Council thus becoming unwieldy in respect of numbers, the local authorities' interests could be looked after by a limited number of persons nominated by the Ministry of Health.

These suggestions are made having regard to the terms of Section 3, subsection (*e*), which permits of local authorities combining for the purpose of carrying out anything permissible under this section. Without this permission much of what I have suggested would be impracticable. One after-care worker will be sufficient for smaller local authorities, each of which will thus secure an efficient after-care service on economical terms.

The headquarters of the local after-care officer could well be the out- and in-patient clinic maintained or subsidized by the local authority.

The cost of providing suitable convalescent institutions will be pooled among all the local authorities, which must also prove an economy, even in the case of the largest of them.

I feel that my proposals will not fail to receive serious consideration, and I commend them to this Conference as a basis, at least, from which to proceed.

In dealing with this subject I have so far touched upon the employment in the psychiatric field of two groups of social workers, namely, in regard to persons entering upon psychiatric treatment, and in regard to those leaving it.

It must be understood that my remarks are equally applicable to these two groups of workers in regard to every kind of institution doing mental work, whether a public mental hospital, a special clinic for early cases, or those out-patient departments with some beds preferably attached to general hospitals (voluntary or municipal), which I am anxious to see *inter alia*, placed at the service of those whose treatment does not necessarily come under the provisions of the Mental Treatment or Lunacy Acts. I refer to mild cases of psycho-neuroses, of hypochondriasis, fatigue or apathy, morbid shyness, inferiority feeling, memory hallucinations, feeling of unreality, fears and obsessions, etc., which, if not skilfully treated, become chronic, result in years of suffering and unhappiness, and are productive of a vast amount of avoidable invalidism and inefficiency. Included are those whose mental distress, worry and failure follow upon uncongenial, monotonous, exhausting or nerve-racking occupations and for whom vocational guidance is necessary.

Many of them are a heavy tax on public assistance and the benevolent funds of industries and on employers of labour generally.

Some of them spend years in making the entire round of the departments of a general hospital and derive no benefit therefrom.

In my opinion such psychiatric departments of general hospitals should also undertake child guidance, and operate as children's clinics, so as to secure the cooperation of other departments of the hospital in this work.

I am now free to touch briefly upon social workers in regard to what I consider the first line of attack on the problem of the occurrence of mental disorder and mental inefficiency, and incidentally of the need in many cases for public assistance.

Children, to the detached observer, are good or bad, or indifferently either, whatever is the parental opinion. Probably most of them are indifferently good or bad. Some, however, are mentally defective, others are dull and backward or difficult, and others still may be either of these, but in addition notoriously bad. In any case children will become the responsible citizens of to-morrow, and the future of humanity depends upon the care taken in their upbringing which is a matter of to-day—especially those who show early failure of adaptability to home and school surroundings.

It must be remembered that, setting aside the frankly defective who cannot fail under modern conditions to receive adequate attention, it is just these dull, backward, difficult, nervous or bad children who, if left to their own resources and not assisted in regard to parental control and home and school conditions, or in other words neglected, misunderstood or inappropriately treated, may become later the source of great trouble and expense to everybody and to the State. On the one hand they may become social misfits, cranks, extremists, eccentrics, anti-this, that and the other, rogues and vagabonds, unemployables, confirmed gamblers or habitual delinquents, or, on the other hand, nervous invalids or mentally afflicted persons—all grave economic losses to the community.

In almost every case the state of these derelicts of civilization is a product of underlying causes extending over many years and commonly originating during a distorted or evil infancy.

As to the remedy: the present brick-and-mortar, statistical, and other unbiological and passive treatment has proved totally inadequate, and I suggest the time has come to replace it by something more biological and dynamic a beginning of which has already been made. This brings me to a group of social workers whose effectiveness in the domain of prophylaxis cannot be doubted.

In regard to child guidance, two problems, the problem of the child and the problem of the parents must be faced, for the

solution of which somebody must enter the home. To quote a pretty work by Esther Loring Richards, parents frequently forget that " the personality of a child is like a highly-polished mahogany table, prone to take the dust and scratches of all sorts of things in its environment."

Careless, quarrelsome and badly-behaved parents often fail to realize that parental disharmonies, disrespect for religion and the law, biting, sarcastic or angry remarks about persons and things, let alone drunkenness and crime, all have their effects on the growing mind of the child, quite apart from the parents' specific attitude to the child—its longings, its endless questions, its need for sympathy, encouragement and affection.

On the other hand the variety of the indications of maladjustments in the child are amazing, and many of them all too difficult for the parents to tackle alone—hence neglect, with disastrous consequences to the child's future and to the State.

To mention a few: bad habits, such as thumb-sucking, nail-biting, bed-wetting, food fads, self-abuse, etc.; bad behaviour, such as stealing, lying, truancy, cruelty, destructiveness, disodedience, defiance, fire-raising, bragging, showing off, etc.; personality traits, such as over-sensitivity, shyness, pugnacity, seclusiveness, obstinacy, quarrelsomeness, apathy, restlessness, day-dreaming, fear, nervousness, etc. Then there are the problems represented by fits, sleeplessness, night-terrors, headaches, stammering, mental backwardness, etc.

The complexities of modern life accentuate the difficulties of growth and adjustment in child life as they do in the life of the adult. Compulsory school attendance and the attempt to educate children in a uniform pattern have resulted in a host of personality maladjustments with which our Educational Authorities struggle manfully.

So the child-guidance social worker is a necessity not only to many parents, but also to school teachers and school doctors.

The employment of trained social workers in every aspect of child life I venture to suggest is a division of the first line of attack in regard to the social problems which burden you and your finances, including mental inadequacy and disorder.

In this first line is also included the employment of skilled social workers for the prevention of mental breakdown in the adult and the detection of its earliest signs, which brings me to still another group of social workers who I suggest should be an integral part of public assistance.

This proposed activity I have described elsewhere in the following words:

"The bringing together of the poor and indigent under the direct supervision of a public assistance committee of a local authority made possible by the Local Government Act of 1929, offers an opportunity for establishing fruitful measures in regard to both prophylaxis and early treatment of mental or nervous breakdown. The largely passive *rôle* played by the Poor Law authorities, by merely treating cases brought to them by necessity, should now be changed to an active intervention. The attack should be made by the utilization of trained social workers, who, during their regular visits to the homes of the poor, will encounter cases whose mental state requires immediate attention to avoid a definite breakdown. These public assistance social workers should coordinate those of voluntary agencies capable of assisting in this work. Such workers would, in due course, replace the relieving officers, and bring to bear a skill and training in social work not hitherto concentrated on the prophylaxis in mental disorders and the promotion of positive mental health. The head administrative official of a public assistance committee should be a psychiatrist or a psychiatrically-trained and experienced social worker. The point of this is that though people who seek assistance during times of unemployment due to lock-outs, strikes, economic conditions, etc., may not be the subjects of any mental or nervous disturbance, there is no doubt that the people who habitually seek public assistance are of a subnormal mentality. Left to their own resources they are incapable of facing the difficulties of life and fail in the struggle for existence. Social workers, on their own initiative, might be able to deal with some of the milder cases of mental and nervous exhaustion by appropriate advice; or refer them to their own doctor for recommendation to the mental out-patient department of a voluntary or county general hospital. The social workers would keep case-records, which would be a valuable source of information for the local authorities. Cases which pass from observation units, and from after-care workers on completing rehabilitation, would find in the public assistance social worker a friend to advise and help them in necessity. Those short periods of residence in the observation wards of public institutions—that inflow and outflow of the same cases—would be less, and fewer would ultimately find their way to the public mental hospital or the police court."

These two recent Acts of Parliament, the Local Government Act

of 1929, and the Mental Treatment Act of 1930, offer you a vista of hope and possibilities of great achievements in a sphere of public welfare in which progress has been in many respects disappointing. Much has been done, in fact I think all has been done, that was possible by past methods and opportunities.

The outlook is better now than it has ever been, and psychiatry has a chance of attaining a first place in preventive medicine—the highest plane of all branches of medical science. If successful, as I feel sure it will be, it will go a long way towards the solution of many social problems costly to individuals, communities and the State.

The utilization to the uttermost of the trained social worker in the manner suggested in my paper is likely, I submit, to be more fruitful and more economical in the long run, than the building and organization of mental hospitals, mainly housing " end-products " of causes many of which are preventable if tackled at the right time, in the right place and by the right methods.

As to how this can be done, I trust I have contributed something, if only a little, towards your enlightenment.

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