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Contents.

The Value of Social Service in the Out-Patient Treatment of Mental Disorder.

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During the last fifty years a great change has taken place in the general attitude towards mental disorder, not only in that of the physician but in that of the layman as well. Advance in thought is a difficult thing to measure, but a comparison of the writings and teachings of half-a-century ago with those of to-day will show how completely the outlook has changed and from what a different angle the whole problem is viewed.

Until comparatively recently the words, " early mental disorder," had little meaning. The mentally unfit were thought to fall into three fairly distinct categories : the deficient, the neurotic and the psychotic. The low-grade imbeciles were easily recognised and a limited number of institutions existed for their care, the insane were shut away in Asylums, and the neurotics wandered from Hospital to Hospital and from doctor to doctor seeking relief from physical symptoms which owed their origin to no physical disease whatever. Only of recent years has it begun to be realised what a vast borderland lies between each of these extremes and the normal. The high-grade feeble-minded merging into the merely dull and backward, the unstable and excitable patient and the man or woman who always has a bilious attack or some distressing ailment whenever his or her help is most needed at home or in business—these and many other examples crowd to our minds from the borderland of mental defect and the psycho-neurosis. But what of the insane patient? Where does that borderland begin, and how can the patient who reaches it be helped back to normality?

Broadly speaking, I think the borderland is inhabited by those who fail to adjust—or find great difficulty in adjusting themselves—to their environment and the demands of life. They can only be helped back to normality (and this applies to the psycho-neurotic patient also) by a sympathetic understanding of their difficulties and limitations, and a re-education to a new attitude of mind. No one can go through life without some anxieties, emotional stress, disappointments, failures, but the normal man meets each as it comes, with at least a sense of the necessity to adjust himself to the new situation, while the abnormal exhausts himself with conflicts and excessive emotions and anxieties. He does not always voice his unhappy or distressing thoughts, and it is often most difficult to recognise the way he is tending, or having recognised it to induce him to seek the help and advice that would save him. And even when his condition has been realised and the man himself persuaded to have treatment, the difficulties in the way of obtaining it for him are often insuperable. Outside of London and a few of the big cities or University towns, there may be no specialists near by to take the patient to, no Clinics or Hospitals where he could be treated and no societies to tackle the social and economic side of his problem. At first sight then it would seem useless to have advanced so far and still to be able to do so little for the individual patient. It must be acknowledged that the advance in thought and knowledge has far outstripped the advance in action, but the signs are not wanting that a further big development is likely to take place in the near future. Once the fundamental fact has been accepted that mental disorder can be prevented, arrested or cured by early treatment, it must inevitably follow that the means for providing it will be insistently demanded until it is available for all who need it.

Before this demand can be made with conviction and insistence, however, it needs to be more fully realised than it is at present, what can be done by early treatment for borderland cases.

As this paper is mainly concerned with Out-Patient Clinics, I propose to confine my survey to out-patient treatment, and where this is insufficient in particular cases to indicate the means at our disposal for providing in-patient care or observation. I cannot too strongly emphasise the importance for the successful working of an Out-Patient Clinic of having easy access to Hospitals and Homes for urgent cases.

The kind of accommodation required will vary in different cases—some needing Hospital nursing, others discipline and training, others only rest and feeding-up, but without the possibility of suitable facilities, it will often prove difficult to help many otherwise hopeful cases.

To return then to the three types of borderland cases: (*a*) the dull and backward or defective; (*b*) the neurotic; and (*c*) the psychotic.

(*a*) The borderline mental defective can be helped at an O.P. Clinic in several ways. In the first place a definite diagnosis can often be made by the physician in doubtful cases, and the procedure for dealing with the patients clearly indicated. Secondly, in cases where a diagnosis cannot be made without further observation and training the right kind of Home or Institution can be found through the social service worker, and arrangements made for the patient to be seen at the Clinic at stated intervals. Thirdly, there are some clinical types of mental defectives whose condition can be greatly improved by regular medical treatment—as, for example, in cases where some glandular defect exists.

Example—

C.K., a girl of 15, brought to the Hospital on account of fits, childish behaviour and backwardness. Investigation showed that she had been backward at school (but never considered for a Special School). She had failed to respond to responsibilities thrust upon her

as a result of her mother's death. At the medical examination she was found not to be certifiable as mentally defective, her fits were definitely diagnosed as hysterical, and her general condition one of adolescent instability. A prolonged period in a Training Home was advised. Through the social service worker a vacancy was found for her in a Home, and she remained there for 18 months. Though still somewhat difficult and excitable on her return, she has improved sufficiently to be tried in service, and appears to be succeeding quite well.

(*b*) Under the heading of " neurotics " are undoubtedly found some of the most difficult of all Clinic patients : those suffering from anxiety neurosis, compulsion neurosis, hysteria or exhaustion—all present problems which at first sight seem almost insoluble. With the hysteric of long standing, little can be done in an Out Patient department, but when, as sometimes happens, they are brought to the Clinic before the hysterical symptoms have become more or less fixed, it is often possible, by a judicious mixture of sternness, reason and real understanding, to foster a latent sense of pride and self-respect and prevent them from becoming too great a burden on the community in which they live.

Example—

C.H., a young man with a wife and baby a few months old. He was an intelligent man with a good job in an Engineering Works, but complained that it was too heavy. He felt ill-used because all but a few shillings of his earnings had to be paid over for the upkeep of the home. He complained of headaches and he looked run down and ill. Eleven months after the birth of the first child, his wife gave birth to twins. The same week the patient said he felt too ill to work another day, went on sick pay and Guardians' relief, and sat about all day in the one room occupied by the family. As he was in a poor state physically, convalescence was arranged for him, and he returned after three weeks in excellent health. For weeks, however, he refused to return to work, though his job remained open for him, various symptoms being described to account for this. The application of some sternness, a mixture of home truths and appeal to his self-respect, had the desired effect. He returned to work and has kept at it since.

The most hopeful cases of neurosis are those suffering from anxiety due to some definite cause and exhaustion following prolonged strain. A motor driver who has been in a serious street accident, will perhaps drive easily for a day or two after and then begin to suffer from sleeplessness and fear. Or a woman whose husband has been out of work for months will collapse in a state of utter exhaustion as soon as he gets a regular job and the tension is relaxed. In such cases, a few weeks' convalescence will often be sufficient to restore the patient's equilibrium and prevent a more serious breakdown.

In anxiety states where the patient has a thoroughly unsatisfactory home environment, even though this cannot be radically altered much can be done by strengthening and encouraging the patient to meet the demands made upon him, and by inducing a more sympathetic attitude in the relatives.

Example—

R.D., a woman of 39, a war widow with two children. Five years previously she had had an accident and hurt her head. Three years after she began to have headaches. Another fall on the back of her head seemed to increase the severity of the headaches, and she feared she had a tumor forming. She was reassured as to this, treated medically for the headaches, and given three weeks' convalescence. She recovered completely, but continues to visit the Hospital from time to time, and when she feels she is getting below par, a short holiday is sufficient to restore her to normal health.

(*c*) The psychotic patients met with at an out-patient Clinic vary greatly as to degrees of instability. There are those who suffer from moods and feelings which are only a slight exaggeration of those common to us all, but which at an intenser level are seen in the Wards of any Mental Hospital. There are the chronically deluded or hallucinated patients who yet manage to carry on their work in the community, and there are those who have had previous breakdowns, know the signs and symptoms and come to the Clinic for help and advice.

Undoubtedly the first are those most likely to benefit by Clinic treatment, but, unfortunately, they are often the last to seek the help of the physician, feeling that they ought to be able to conquer their moods and depressed or excitable feelings by the exercise of "will-power." It is to be hoped that in time people will cease to have any shame or fear in asking for expert help and advice as soon as they begin to feel their own power of control inadequate to meet the demands made upon it, as the lessening of mental stress and increase of happiness and efficiency which would result, can only be realised by those who have watched the unequal struggle waged by the unstable patient thrown entirely on his or her own resources. The intense inner conflict in time produces a state of complete mental and physical exhaustion. A short term of convalescence in such a case is not sufficient as in the type of exhaustion mentioned above: the causes lie deep in the past experiences and mental make-up of the patient and only a prolonged course of psycho-therapeutic treatment can avail to dissolve the inner discord.

Another hopeful type of patient is the early dementia præcox, at one time thought to be quite incurable. An illustrative case will best show what can be done and what line of treatment seems most conducive of good results.

Example—

M.C., a girl of 15, was brought to the Hospital with a history of alternate attacks of depression and excitement during the previous two or three months. She had lost her first job (in a grocer's shop), was childish and naughty in behaviour, had a vacant expression and foolish way of talking. Her appearance was that of a mental defective with some superimposed instability. On investigation, however, it was found that she had been above the average at school, and had always been a well-behaved girl until her present sudden breakdown. Between her first and second visit to the Hospital, she became so violent and unmanageable at home that certification under the Lunacy Act was seriously contemplated. Finally, however, a Home was found willing to accept her on condition that she was removed immediately if her conduct proved impossible. Great credit is due to the Sisters in charge of this Home for their successful handling of a most difficult case. At first the task seemed hopeless. The patient would alternate between moods of silliness and excitability, and periods of utter apathy, when she had to be forced to eat or move. At the end of four months she was holding her own with the other girls and behaving perfectly rationally. Normal balance is not yet restored, but progress is steady and sure. An essential element in the handling of this case has been the regular Clinic treatment the patient has had during her stay in the Home. The weekly or fortnightly visits to the Hospital have made it possible for the Sisters to consult the physician in all phases of the illness, and his direct contact with the patient has enabled him to divert her thoughts from day dreams and back to realities.

I have quoted this case at some length, because it is typical of many and seems to prove that the environment of a small Home among normal girls, and above all under sympathetic teachers provides the best atmosphere in adolescent cases for restoring normal balance.

It may seem strange that I should include the chronic case among those suitable for an out-patient Clinic. Surely, it will be argued, they should be put into Mental Hospitals and kept there. It is true that their delusions and hallucinations render them certifiable but many of them manage to maintain themselves at work and are far less harmful to themselves or others than the borderline excited or depressed patient. In many cases, regular attendance at the Clinic just keeps them going and enables a watch to be kept on them for signs of any serious deterioration. Only a limited number of such cases can be suitably handled at a Clinic, however, as there might be a danger of their outnumbering the more hopeful cases for which the Clinic is primarily intended.

The mental patient who recovers from an acute attack of mania or some other form of mental disorder is generally anxious to cut free from all connec-

tion with Hospitals or Clinics and on the whole this is a healthy instinct which it is right to encourage. At the same time, I cannot help feeling that much might be done to prevent or delay recurrent attacks if the patient were in touch with the physician of an Out Patient Clinic. If once an attitude of trust and confidence in the Clinic had been established, it would not be necessary for patients of this type to attend often—they or their relatives would know when to seek the help of the physician. A much closer co-operation between Mental Hospital Authorities, After-Care Associations and Out Patient Clinics than at present exists is needed, and would, I am sure, lead to much useful and constructive work.

In many parts of the country Clinics where patients such as I have described can be treated are non-existent, but in London several types of Clinic are found. In most of the big General Hospitals there is a Neurological department in charge of eminent specialists: at the Middlesex Hospital the department is entirely staffed (as well as two small Wards for in-patients) by the physicians and nurses from St. Luke's Mental Hospital: Bethlem Royal Hospital and the Maudsley Hospital both have out-patient departments, and there is an independent Clinic under the direction of Dr. Crichton Miller known as the Tavistock Clinic.

A short description of the work of the Out-Patient Department at Bethlem and the Neurological Department at Guy's Hospitals may be of interest.

At Bethlem, as in many Clinics, the patients are divided into organic and functional cases, the former being treated by visiting neurologists and the latter by the psychiatrists on the Bethlem staff. There is one weekly morning Clinic for the examination of mental defectives, and one afternoon Clinic a week when the Hospital pathologist attends to see cases referred to him. In addition, there is a speech defect Clinic once a week, while massage and electrical treatment is given by Sisters and male attendants on certain mornings in the week.

At Guy's Hospital, as in other Medical Schools, a large class of students attends at each Clinic. Before the arrival of the specialist in charge, certain of the students appointed to act as " clerks " carry out a routine examination of all new patients, and the physician later re-examines and demonstrates each case. The numbers attending are greater than at Bethlem, and there is a greater proportion of organic cases.

The social work at the two Hospitals is both different and alike: different as to the organisation and duties while at the Hospital, alike as to the kind of social work required.

At Bethlem the social service worker is also the Almoner, and the routine work of collecting payments, keeping indexes and records comes under her jurisdiction. At Guy's, the work is confined to visiting and investigating cases and carrying out the social work required. To prevent any over-lapping or confusion with the Almoner's department, all correspondence on cases passes through that office, and officially the social service worker remains anonymous. The duty of taking a Binet-Simon test on certain doubtful or borderline cases of mental defect falls to the worker, when the patient is interviewed privately and the result of the tests submitted to the physician.

With regard to the work of investigation and following up of the cases the home visit is of the utmost importance for the following reasons :—

Firstly, because in psychological medicine the most important factors in the home environment are not always those relating to the economic conditions, but lie deeper and are more subtle. The most satisfactory and comfortable home, from

the material point of view, may yet contain the elements in the causation of the patient's illness.

Secondly, because of the relationship of confidence and friendliness which is thereby established between the patient and the worker, and thirdly the visit is important in order that other members of the family may be seen and something of the patient's re-action to them, and theirs to him, observed at first hand.

The social service worker acts as the liaison officer between the physician and the home. Her report of the actual social environment, the patient's past history, educational attainments, ability to get and keep work and his re-action to his immediate family circle are all of assistance to the physician in building up a complete picture of the patient as an individual problem.

Having the outside material collected by her to supplement his own clinical observations and deductions, he can then proceed to outline the course of treatment necessary for the particular case. This will naturally fall under three distinct headings: pharmaceutic, psycho-therapeutic and environmental.

With the first the social worker has no concern. With the second she is concerned only so far as she re-inforces the friendly and receptive attitude of the patient towards the Clinic, or can keep the physician in touch with any changing factors in the home at work upon him. With the third, the environmental situation, her help may be invaluable. If the patient requires Hospital or Infirmary treatment, she acts as the connecting link between the Hospital or the Poor Law and the Clinic, and she should keep in touch with the patient sufficiently to know when he is discharged and should attend the Clinic again. If, on the other hand, he is not ill enough to be sent to Hospital or Infirmary, and yet cannot be nursed at home, the social service worker must find the most suitable place for him to go to, and for this contact with and knowledge of many different societies and institutions is essential. Again, should it be advised that the patient remain at home, the physician looks to the worker to help the relatives by showing them how best to create the atmosphere around the patient which he considers necessary for his ultimate recovery.

It will be readily realised that the work required in connection with the social service is very personal, but if I may be allowed a paradox, it must remain impersonal too. By this I mean that each case must be handled by the worker, not only in her contact with the patient, but also with his relatives and friends on a personal basis, so that they look upon her as a friend: while, at the same time, her own inner attitude must remain strictly impartial—unswayed by excessive emotion or violent partisanship—and untrammelled by preconceived theories or ideas. The patient must never feel that he is being caught up in a vast system, as I fear he too often does when he comes in contact with the Poor Law, Ministry of Pensions or other well organised body. Neither must he feel that he flounders in a sea of uncertainty and emotionalism equal to his own. In fact, the ideal for the social service worker is *balance*—the even holding of the scales between emotional sympathy and coldness or indifference, and between over systematisation and complete lack of organisation which could only mean hopeless inefficiency.

She should have a clear idea of the bigger issues at stake in the treatment of each case, involving, not only her own ideal for the work, but that towards which the whole staff of the Clinic are striving. To the driven, anxious, harassed patient, the Clinic should be a refuge to which he can turn for the stability and quiet assurance which he so pitifully lacks within himself, and this atmosphere can only be created in a Clinic where personal motives have been eliminated and the members of the staff work in complete harmony and loyalty.

The whole subject of early treatment, and the provision of Hospitals or Wards for voluntary boarders as well as many more out-patient clinics, is likely to be the subject of far-reaching recommendations when the report of the Royal Commission now sitting comes to be published. It is important that social workers and all who have to deal with the unstable and unbalanced should have clear ideas as to the type of Hospital or Clinic most needed in their locality.

The Out Patient Clinic attached to the General Hospital of the district has many advantages. The physicians working at such a Clinic have fully equipped laboratories at their command for X-Ray and bacteriological examinations, massage department and speech clinic, as well as easy access to other departments of the Hospital for various physical examinations. Patients are often more easily persuaded to attend a special department of a general Hospital than to go to one definitely associated with mental disorder. On the other hand, it must be borne in mind that (judging from the experience of the London Hospitals) the large number of patients attending at each Clinic, render prolonged individual treatment of functional cases exceedingly difficult.

An Out Patient Clinic connected with a Mental Hospital, if provision were made for the reception of voluntary boarders, would also have advantages. The patients would receive a continuity of treatment impossible in the General Hospital, attending first as out-patients, then, if necessary, as voluntary boarders, and on discharge keeping in touch with the Clinic so long as they felt the need of help and support in carrying on their work in the community. The great disadvantage would, I think, lie in the fact that many really early cases would refuse to seek assistance, on account of the present popular prejudice against any place connected with a Mental Hospital.

It seems to me that the ideal scheme would be one by which the advantages of both types could be secured, and the disadvantages minimised. If O.P. Clinics could be established within easy distance of both the General and County Mental Hospitals, staffed on the organic side by the neurologists of the General Hospital and on the functional side by psychiatrists of the Mental Hospital, with power to use the facilities of both Hospitals for individual cases, there would be far more hope of accomplishing constructive work than would be possible in any one-sided arrangement. Needless to say, an essential element in any scheme would be an adequate social service. Probably few clinics would have a sufficient number of cases to necessitate the appointment of a whole time worker, nor would there in most areas be a second Clinic with which to share her services. In Counties or County Boroughs where a Mental Welfare Association is in existence, it should be possible in many cases for the Clinic Authorities to appoint a member of the staff of the Association for part time. They would thus acquire an experienced worker, and one who, through her connection with the Mental Welfare Association, would be in touch with other branches of mental work in the district.

There are vast possibilities for the development of O.P. Clinic work in this country. Public opinion is slowly but surely awakening to the need for it, many Hospitals and public Authoritites would welcome a strong lead, and it behoves those already engaged in mental welfare work to come forward with practical schemes, and to work strenuously and whole-heartedly for their inauguration. Thus and thus only will the population of our Mental Hospitals be reduced, and the burden of mental suffering, borne by so many of our fellow citizens, be lightened.