The 1890 Lunacy Act formalized the process of admission to asylums in order t safeguard against illegal detainment. However, Jones maintains that 'from a medic point of view it was out of date before it was passed' (1972: 226). A situation legalism versus custodialism had occurred. Because of concerns about civil right asylums could only take certified patients, who could only be certified when it w obvious to a justice of the peace that they needed containment. By this point, th principles of early diagnosis and the treatment of mild or acute cases had been los the asylum's work thus became largely custodial. Rogers and Pilgrim argue that, i the wake of this Act, 'psychiatry settled down as a paternalistic asylum based disc pline with little to show for itself as a medical specialism offering genuine cures fo madness' (1996: 51).

Reflection exercise

Why would the Victorians believe that institutional care was the best provision for the mentally distressed? Why did this view change?

THE ESTABLISHMENT OF MENTAL HOSPITALS

The start of the twentieth century was to witness further controversy concerning th treatment of the mentally distressed, not least from the effects of the First Worl War (1914–18). As a result of the experiences of war, many soldiers were sufferin breakdown (shellshock), with figures showing that this was more prevalent amon upper-middle-class officers (Rogers and Pilgrim, 1996). This caused a crisis for th existing services that had until this point been based on bio-deterministic ideas an institutional containment. Government and psychiatrists were forced to turn the attention to stress conditions that were self-evidently environmental, the victims which were deemed to be 'honourable' and not 'degenerate'.

After the First World War 'conditions in the mental hospitals, as they were no being increasingly called, began to improve again' (Jones, 1993: 126). Though th 1890 Lunacy Act was still in force, its Commission was replaced under the 191 Mental Deficiency Act by the Board of Control which was to deal with both ment illness and mental deficiency. Responsibility for the oversight of the Board was tran ferred from the Lord Chancellor's Department to the Home Office; a move that Jon argues 'was away from legal control' (1993: 124). In 1919 the Ministry of Health w set up; the same year the Board of Control drafted a Report for the governme Reconstruction Committee which made major recommendations for the future. The included: treatment in mental hospitals without certification; establishing psychiat units and out-patient clinics in general hospitals; and the provision of funds to volu tary societies for aftercare (Jones, 1993). These recommendations and public discu sion about the 1922 Prestwich Hospital Inquiry into allegations of poor treatment, l to the establishment of a Royal Commission in 1924 chaired by Hugh Pattison (la

Lord Macmillan). The Macmillan Commission was to inquire into certification and detention of people who were of unsound mind, and into treatment without certification for people with a mental disorder.

The Commission reported in 1926 and re-stated the principles stated earlier by the Board of Control. Though the Commission was critical of aspects of the system it rejected suggestions that there were widespread infringements of liberty. They recommended voluntary admission on the written application of the patient without medical recommendation, but once admitted, discharge would be subject to a requirement of 72 hours notice. They also proposed greater protection for doctors against accusations of acting in bad faith or without reasonable care (Fennell, 1996). Rogers and Pilgrim argue that the Commission's position was one:

> which is still bedevilling modern attempts to make therapeutic law. On the one hand there was an emphasis on the need for benign care, curative intent and consideration for the sufferers' needs. On the other hand, the emphasis on the need for the use of force in the case of mental illness actually requires the deprivation of liberty without trial: the removal of a fundamental civil right. (1996: 55)

The 1930 Mental Treatment Act that followed the Macmillan Commission incorporated such contradiction. While certification procedures continued under the 1890 Act, two new categories of patient admission were introduced. A 'voluntary patient' could make a written application for treatment and discharge themselves with 72 hours notice. 'Temporary patients' were defined as persons 'suffering from mental illness and likely to benefit by temporary treatment, but for the time being incapable of expressing (themselves) as willing or unwilling to receive such treatment' (Jones, 1993: 135). Psychiatric out-patient clinics were to be funded and new terminology was to be used. The asylum name was to be replaced by 'mental hospital' or simple 'hospital' and the term 'lunatic' by 'person of unsound mind'. The Macmillan reforms went ahead with voluntary admissions reaching 35.2 per cent of all admissions by 1938 and out-patient clinics attached to general hospitals increasing in number. Staffing numbers improved and there were moves to have more unlocked wards except for very disturbed patients (Jones, 1993). Systems of parole were used for patients and professional training improved along with 'social workers' carrying out domiciliary visits.

THE DEVELOPMENT OF SOCIAL WORK PRACTICE WITH THE MENTALLY DISTRESSED

Britain was among the first societies to have identifiable social work activity. It originally manifested itself in the final quarter of the nineteenth century as voluntary (and predominantly female) work and it focused on the undesirable consequences of industrialization and urbanization (Jordan, 1997). Social problems such as ill health and disease, poor housing, overcrowding, prostitution, abuse of children and alcohol abuse, which were largely invisible in the countryside,

became commonplace in the towns and cities. Living conditions for the poor in major towns and cities were squalid, unsanitary, poorly ventilated and dangerous to health. Poverty was rife and the absence of available work often meant the difference between living and literally starving. Frederick Engels visited England from 1842 to 1844 and described his observations in graphic detail – 'in every manufacturing town there is to be seen, a multitude of people, especially women and children going about barefoot' (1973: 97). Life was short for both children and adults. In Manchester, for example, 'more than fifty seven per cent of the children of the working class perish before their fifth year' (1973: 131). For adults, official figures for 1839–40 show that for every 45 members of the population, one died every year (Engels, 1973).

Middle-class city dwellers perceived dangers from the social deprivation experienced by the working classes and called for something to be done to contain and control this threat from the 'dangerous classes'. The response was a variety of state social welfare initiatives which were created in the nineteenth century. Public schemes for sanitation, education, prisons, policing, workhouses and asylums for the mentally ill were all created. Despite many families only surviving with the support of charity, concern focused yet again on the 'deserving' and the 'undeserving poor'. In 1870 the London Charity Organisation Society was established to both provide principles for, and to coordinate, charitable giving and to repress mendicity (idleness). Assessment and help were based around a family's 'character', with past histories and records being kept. Viewed by many as the beginning of 'social work' in society, Payne argues that 'this was the beginning of ... assessment as a bedrock of social work practice' (2005: 36).

Psychiatric social work (PSW) developed as a practice mainly in mental hospitals and child guidance clinics between the wars around the 1930s. The Tavistock Clinic founded in 1920 also used social workers, initially to support and assist the recovery of shellshocked patients, but moved on to provide specialist analytical training and support for mental health workers. As welfare activities expanded during the inter-war years elements of social work were drawn into the operations of the state. Probation was tied up with the legal system; almoners were operating on the margins of the nursing and medical professions, while mental health workers were in a field of practice dominated by the psychiatric profession (Clarke, 1993).

As with the First World War, the Second World War brought great upheaval and new psychiatric problems. Again, men working in the mental health system (doctors, nurses, porters) were enrolled to assist in the war effort. Jones (1993) notes that over half of the accommodation in mental hospitals was taken over for emergency purposes, out-patient clinics collapsed for want of staff and, though it did not happen, there was considerable apprehension that there may be mass panic and widespread mental breakdown. Before the war was over, William Beveridge's *Report on Social Insurance and Allied Services* was published (1942), directed at the abolition of squalor, want, ignorance, disease and idleness. The new proposals had three central themes, namely, full employment, the provision of children's allowances and the establishment of a National Health Service which would be 'free at the point of delivery', and paid for by a National Insurance Scheme. At first it was not decided whether mental

hospitals were to be incorporated into the NHS scheme but the 1944 White Paper *A National Health Service* and a joint Psychological Association and Royal College of Physicians Report, *The Future Organization of Psychiatric Services*, in 1945, both argued for its inclusion. As a result, Jones argues that 'the artificial divorce between the treatment of the mind and the treatment of the body would be ended, and the gap between the treatment of the psychoses (largely in county mental hospitals) and the treatment of the neuroses (largely in voluntary hospitals and private practice) would be bridged' (1993: 143). Reform of the existing mental health services was called for and the government's response was to set up the Royal Commission on Mental Illness and Mental Deficiency in 1954. The Commission reported in 1957 and the resulting Bill put before the Lords was introduced by Lord Hailsham who described it as 'the first fundamental revision of the English mental health laws since 1845' (Jones, 1993: 156). The Mental Health Act 1959 which followed created a new basis for the treatment of mental distress as an 'illness' essentially akin to any physical illness (Jones, 1993). Rivett comments that 'the Act aimed to break down segregation, and the feelings of isolation, neglect and frustration. Services would now be planned across hospital and community boundaries, by specialists, family doctors, and local authority staff, nurses and social workers' (1997: 159). An awareness of institutionalization led many to believe that it was in the best interests of those who could to live in the community, and local authorities began expanding domiciliary services, hostels, day centres, social clubs and day hospitals for the mentally ill with this objective in mind.

Irvine notes that during the 1950s, 'demand for PSWs had spread far outside the bounds of mental hospitals and child guidance clinics with debate existing about whether they were primarily social workers or therapists' (1978: 176). Either way, their energy and initiative in pioneering community care schemes contributed to the increasing role played by social workers. Although medicine was the primary profession dealing with mental disorder, 'social work increasingly played a complementary role when from the 1950s the profound influence which the family and social environment had on the well being and level of social functioning of mentally disordered people became clearer' (Younghusband, 1978: 165).

The 1957 Royal Commission on the Law relating to Mental Illness and Mental Deficiency thought that social work with the families of in-patients was desirable and that social work for patients not receiving hospital treatment, including those who had left hospital, should be the responsibility of the local authorities. This had the effect of greatly increasing the demand for social workers and trained staff in homes and hostels – a demand that was to continue over the coming decades. Titmuss observes that 'whenever the British people have identified a social problem there has followed a national call for more social work and more trained social workers' (1968: 85). Similarly, Walton states that 'for much of the second half of the twentieth century, social work education and training have been insufficient in quantity and quality to match the increasing demands on the profession' (1975: 209).

The Mental Health Act 1959 established the appointment of social workers as Mental Welfare Officers to carry out duties in relation to the Act. The Act had abolished the distinction between psychiatric and other hospitals and encouraged the development of care in the community. Mental Welfare Officers, employed by local

authorities, were to play a key role in achieving this objective, for in addition t arranging compulsory admission when necessary and attending Mental Healt Tribunals, they could arrange guardianship for private individuals. They supporte individuals in the community by carrying out routine family visits, monitorin progress, arranging day care centre placements and social club attendance, an assisting with employment. In 1961, returns to the Ministry of Health showed tha 1,128 mental health social workers were employed by 146 local authorities i England and Wales (Younghusband, 1978). Despite this, many more social worker were needed and there was something of a staff shortage. Younghusband (1978 observes that in 1967 nearly 185,000 mentally ill or retarded people were receivin local authority mental health services, in close cooperation with mental hospital and GPs. Seventy-one day care centres and 247 social clubs were also in place.

Though many of the large hospitals had closed, others were closing, and many more people were being cared for in the community. Community care was itself stil an objective. The Seebohm Report stated:

> the widespread belief that we have 'community care' of the mentally disordered is, for many parts of the country, still a sad illusion [and that] social workers should be concerned with the whole family, learning how to make a family diagnosis, and be able to take wide responsibility and mobilize a wide range of services. (Seebohm, 1968: paras 353 and 339)

Seebohm's recommendations for the establishment of social service departments were implemented in the 1970 Local Authority Social Services Act, but notably 'none of the first round of Directors appointed came from the mental health field' (Jones, 1993: 187). The Act contained the notion of 'generic' social work, but there was much opposition to the reorganization which separated mental health social workers, hostels, day care and other services from the other local authority mental health services. Danbury (1976) gave evidence of the difficulties some social workers faced at the time because they were unfamiliar with the regulations and procedures, were afraid of the patients, and had received no in-service training. As a result of the pressure applied by Seebohm and the newly formed British Association of Social Workers, the Central Council for Education and Training in Social Work (CCETSW) was formed in 1971. That same year CCETSW introduced the Certificate of Qualification in Social Work (CQSW), the first universally recognized professional qualification in social work in Britain. Thus as Langan suggests 'the modern social worker came into existence as an amalgam of half a dozen or more occupational groups – psychiatric and medical social workers, and "officers" concerned with offenders, children, mental health, housing and educational welfare' (1993: 50).

Reflection exercise

What concerns do you think mental health social workers had about the formation of the 'new' social service departments arising from the 1970 Local Authority Social Services Act?