Report of the Working Party on Social Workers in the Local Authority Health and Welfare Services.

Contributors

Great Britain. Working Party on Social Workers in the Local Authority Health and Welfare Services.
Younghusband, Eileen Louise, Dame, 1902-1981.
Great Britain. Ministry of Health.
Great Britain. Department of Health for Scotland.

Publication/Creation

London : H.M.S.O., 1959.

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DEPARTMENT OF HEALTH FOR SCOTLAND

Report of the Working Party

on

SOCIAL WORKERS

IN THE LOCAL AUTHORITY HEALTH AND WELFARE SERVICES

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INTRODUCTION

The Right Hon. DEREK WALKER SMITH, T.D., Q.C., M.P.,
Minister of Health.

The Right Hon. JOHN S. MACLAY, C.M.G., M.P.,
Secretary of State for Scotland.

1. We were appointed by your predecessors in June, 1955, to inquire into:

> " the proper field of work and the recruitment and training of social workers at all levels in the local authorities' health and welfare services under the National Health Service and National Assistance Acts, and in particular whether there is a place for a general purpose social worker with an in-service training as a basic grade."

2. As in previous comparable inquiries, we have had the help and advice of a Steering Committee, representative of a wide range of responsibility and experience in the needs and working of the services. We have held 3 joint meetings and would like to convey our appreciation of the advice and assistance which we have received. The Steering Committee is not committed by our conclusions, for which we accept sole responsibility, nor do these conclusions necessarily represent the views of individual members of the Steering Committee, or the organisations which they represent.

3. We have held in all 40 meetings. We took oral evidence at 15 of these, including one in Edinburgh to hear Scottish witnesses.

4. We were asked at the outset of the inquiry to have regard to the findings of the Working Party on Health Visitors, the Committee on Social Workers in the Mental Health Services, and the relevant part of the Report of the Committees on Medical Auxiliaries. In addition, we have studied the relevant sections of the Report of the Royal Commission on the Law relating to Mental Illness and Mental Deficiency, the Report of the Committee on Maladjusted Children and the Report of the Committee on the Rehabilitation, Training and Resettlement of Disabled Persons. We have also considered written material covering various aspects of the services, including United Nations and other publications referring to practice in other countries and in Northern Ireland. Opportunity was also taken to discuss special points with officers of the Ministry of Health, and with visitors from Canada and the United States.

5. Seventy-six organisations and individuals submitted written evidence; we invited 39 of these to give oral evidence and discuss points arising from their memoranda. A list of those submitting written or oral evidence is given in Appendix A.

6. In order to obtain information on the organisation and staffing of the services, we asked local authorities in England, Wales and Scotland to complete a questionnaire giving details of the administrative structure of the health and welfare services, staffing (including qualifications and salaries),

use of voluntary organisations, methods of co-ordination and co-operation, and any post-entry training currently provided. A copy of the questionnaire is reproduced as Appendix B. Completed questionnaires were returned by 192 authorities. The material derived from the replies related to 95·4 per cent of the country, and to 99·7 per cent of the population. It has been of the greatest assistance to us in considering the background to our inquiry and we wish to record our appreciation of the care with which the returns were made.

7. In collating the replies we were anxious to distinguish patterns of organisation and staffing, particularly as between urban and rural areas. Existing regional boundaries did not fulfil this purpose and we therefore devised our own grouping of authorities, primarily on a geographical basis. Details of this grouping are given in Appendix C.

8. Small groups of members visited ten local authorities in England, Wales and Scotland to study the working of their services at first hand. These visits, which were most profitable, gave us the opportunity of discussing the general policy, organisation, and development of the services with council members and chief officers. They also enabled us to meet supervisory and field officers and to accompany the latter on their normal visiting duties. We are particularly grateful to these authorities, and to the officers who made the necessary arrangements and were so helpful in discussing the current problems and needs of the services.

9. To supplement our own observations from visits, the information provided in reply to the questionnaire, and written and oral evidence, we decided to promote a small number of field inquiries in different parts of the country to provide factual information on the work of visiting officers in the services concerned, and their functions in relation to other staff. Six authorities in England, Wales and Scotland provided facilities for five surveys on the understanding that the reports would be confidential and that neither the areas nor the persons undertaking the surveys would be identified in our Report. The generous co-operation of these authorities is much appreciated. We were fortunate in obtaining the help of six able investigators whose reports provided us with information of the greatest value. We should like to express our warm appreciation of this help. We do not refer to them by name in accordance with the undertaking given to the authorities concerned. For similar reasons we have not identified the local authorities visited by members. While the field studies relate to only a small number of authorities they support our own observations and the questionnaire returns, and confirm much of the evidence. They therefore form a significant element in our conclusions.

10. We should like to have undertaken a complementary inquiry into the reactions of those using the services. An investigation of this nature would, however, have prolonged our own inquiries unduly. We gained some impressions of 'consumer reactions' from the reports on the field studies and our own visits, and these have been useful in formulating our views.

11. We were struck, in planning the field inquiries, by the lack of any systematic study of the part played by social workers in meeting needs within the framework of the social services. Such information could have had an important bearing on our own inquiry. We should like to draw

attention to the desirability of such study. We think much of the confusion in regard to the functions of social workers in the health and welfare services, as elsewhere, is due to lack of analyses of this kind.

12. A number of witnesses commented on the difficulty of limiting their evidence to social workers in the health and welfare services, since this would mean considering only certain aspects of the total picture. They pointed out the many situations where the work of these officers impinged on that of other social workers (and of workers in related fields) in regard to family or individual problems. In their opinion, a comprehensive review of the training and employment of social workers in the whole field of the social services was required in the light of experience gained since 1948.

13. Throughout our inquiry we have been conscious that other local authority departments and branches of social work need the services of trained social workers. These are, however, outside our terms of reference and our Report must be concentrated on social workers in local authority health and welfare departments. Nonetheless we should like it to be clear that we fully recognise the importance of social work in other services. We are also aware that many of the principles on which our recommendations are based, though applied to the social workers within our terms of reference, are of general application.

14. We have not overlooked the fact that doctors, health visitors, nurses, teachers and others all have a social content in their activities, and we recognise the importance of close working relationships between the various professions in many contexts. But we have necessarily focussed our attention on those whose primary function lies within this field, that is to say on social workers.

15. In view of the various senses in which the terms social work and social worker are used, and also the confused state of training for social work in this country, we have inevitably found difficulties of definition and terminology. For the sake of clarity we indicate below the sense in which we use certain terms throughout the Report.

Social work

The process of helping people, with the aid of appropriate social services, to resolve or mitigate a wide range of personal and social problems which they are unable to meet successfully without such help. This process calls for both knowledge and skill. We endeavour at various points in the Report to describe the nature of the social work function as we see it, or as it has been put to us in evidence. We are conscious that in doing so we, like our witnesses, have not always avoided the pitfalls of making social work sound either esoteric or over-simple.

The social work service

We use this term in the same sense that it is customary to speak of the teaching, health visiting or occupational therapy services, that is to say as the social work component in the general health and welfare services—services which have various other professional and administrative constituents.

Social workers

We use this term to denote those whose primary function in the social services is to carry out the foregoing activities by any one of the three social work methods of work with individuals (casework), groups (groupwork) or communities (community organisation); of these only the first is at present systematically taught or practised in this country. A caseworker in any setting (for example, an almoner or psychiatric social worker) is a social worker whose skill lies in practice with individuals rather than with groups or communities. We quote a definition of casework in paragraph 638. In the present shortage of trained social workers, however, a large number of posts in which social work is the primary function are filled by persons with no training or with some other training. In order to avoid confusion we have found it necessary to refer to these as social work posts or appointments, and to those who hold them as social workers. Nonetheless, we hope that, in line with the situation in the teaching profession, the term 'qualified social worker' will in future be applied only to those who have entered the profession of social work by taking a substantial and recognised qualification, that is either a university or other related professional course or else the general training which we recommend. We think that such workers should be clearly distinguished from those without either of these qualifications who nonetheless occupy social work posts.

Both men and women make a career in social work. We use the feminine gender when the context requires this: otherwise we refer to social workers in the masculine and to their clients as feminine.

Social science qualifications

This term refers to a university degree, diploma or certificate in social science or social studies. Those who have taken one of these courses are regarded by the universities as having laid the foundation for a social work training rather than as being trained social workers. We concur with the view that those who have successfully completed a social science course are not qualified social workers, though we regard them as being in a different category from those who are untrained or who hold some non-social work qualification.

Professionally trained social workers

Those who have successfully completed a university or other related professional course in social work, normally preceded by a social science course. The existing professional courses are enumerated in paragraphs 822 to 827.

Professionally trained and experienced social workers, or social workers with advanced qualifications

We use these terms interchangeably for persons defined immediately above who have also had several years of successful experience in local authority services. In our view, only persons so qualified should be eligible for supervisory, consultant and teaching posts.

Social workers with a general training

Persons who have qualified for a career in social work by successfully completing one of the new courses which we recommend.

Supervision

We use this term to include both an educational and administrative function. Supervision of students in their field work involves a good deal of teaching in order to relate theory to practice, and to help them to attain a better understanding of themselves and other people. It also involves helping students to learn good administrative procedures. Supervision of staff is also intended to provide the same type of guidance and consultation with a view to improving the quality of each worker's performance.

16. This inquiry is the first review of social work in a complex series of services which evolved independently and have reached different stages of development. We found ourselves in fact considering the functions of social workers in nine or ten, rather than in two, distinct services each making its own contribution to the well-being of the community. To this must be attributed both the length of our Report and the fact that our deliberations have taken considerably longer than was originally foreseen.

17. We have been conscious from the outset of the shortage of manpower, and the limited sources of recruitment for all professional workers. It is clearly no solution to the problems of social work in the health and welfare services merely to call attention to the need for more trained workers. Nor do we consider in principle that any one social service more than another has a greater claim to share in the total resources available. We have therefore endeavoured to formulate our conclusions on a realistic basis.

18. We appreciate also that each local authority develops services, and more especially social services, in accordance with national characteristics, traditional patterns, and local conditions, and there is therefore much variety in general policy within the framework of the law, and the standard of service provided. We have had due regard to these variations, particularly in relation to what is possible and desirable, bearing in mind the importance of keeping social needs and economic considerations in balance with each other. An inquiry such as ours must take the long view, however, if potential as well as present needs are to be estimated. The long view is also desirable when, as here, there has been no previous comparable inquiry, and the nature and contribution of social work in the services has only recently been recognised.

19. It is customary in introducing a report to pay tribute to the secretaries. It seems to us that seldom can this tribute have been more richly merited than the one which we now pay to our Joint Secretaries, Mr. G. I. Crawford and Miss E. L. Hope Murray. We are conscious that the weight of material, the complex arrangements in connection with our inquiry, and the work involved in drafting this Report has laid upon their shoulders a heavy burden. We can only say that it was borne with unfailing efficiency and resourcefulness and a lively interest in the success of our endeavours. We desire to pay tribute to Miss P. A. Hooper, Mr. N. Illingworth, Miss M. Heath and Mr. R. P. Pole who have successively given much help. We also wish to express our warm appreciation to Miss G. M. Aves, Chief Welfare Officer of the Ministry of Health, for her attendance at our meetings and for the benefit of her wisdom throughout our inquiry.

20. We now have the honour to present our Report. It is divided into five parts. For ease of reference we open with a summary of conclusions and recommendations. This, we hope, will also enable the reader to refer quickly to those chapters or paragraphs where matters of particular interest are more

fully expounded. Part I describes the development and present picture of the services and thus sketches the background against which our study has been carried out. In Part II we discuss the problems presented to us, and reach conclusions on the future patterns of development in staffing the services, with particular reference to specialisation and whether there is a place for the 'general purpose social worker' referred to in our terms of reference. We consider the training of social workers in Part III and make detailed recommendations. Although we have been limited by our terms of reference to consideration of social workers in local authority health and welfare departments we are well aware of the importance of the relationship between them and workers in other services. We discuss in Part IV the need for liaison with statutory and voluntary services, and for co-operation and co-ordination. Finally in Part V we give our views on the administrative and financial considerations involved in implementing our proposals.

(Signed) EILEEN L. YOUNGHUSBAND (*Chairman*).

ROBINA S. ADDIS.

CHRISTIAN BERRIDGE.

R. HUWS JONES.

C. M. SCOTT.

ANDREW B. SEMPLE.

P. E. STEED.

ELIZABETH SWALLOW.

P. S. TAYLOR.

THOMAS TINTO.

G. I. CRAWFORD
E. L. HOPE MURRAY } *Joint Secretaries.*

6th February, 1959.

SUMMARY OF MAIN CONCLUSIONS AND RECOMMENDATIONS

21. Below are summarised the main conclusions and recommendations contained in Parts II, III and IV. These do not exhaustively cover points made in the text, which should be read in its entirety.

PURPOSE AND FUNCTION OF SOCIAL WORK AND SOCIAL WORKERS

22. The purpose of social work is to help individuals or families with various problems, and to overcome or lessen these so that they may achieve a better personal, family, or social adjustment. The function of social workers is to assess the extent of these problems, to give appropriate help, and to offer a supporting relationship when this is required to give people confidence to overcome difficulties. This may include supplying information, providing practical assistance or material help, or bringing about environmental changes as well as helping to lessen stress.

23. The aim of social workers in the health and welfare services is to assist individuals or families with a specific need, a disability or a misfortune. The variety and degree of personal, family and social problems among those using the health and welfare services necessitates more than one category of social worker. The degree of skill needed in relation to the complexity of the situation should determine the worker required in any given case.

(Paragraphs 615–638.)

Varieties of need for social work

24. The range of need throughout the health and welfare services can broadly be divided into three categories.

(*a*) People with straightforward or obvious needs who require material help, some simple service, or a periodic visit.

(*b*) People with more complex problems who require systematic help from trained social workers.

(*c*) People with problems of special difficulty requiring skilled help by professionally trained and experienced social workers.

25. These gradations apply in every group of services, to the mentally disordered, the blind, the deaf, the physically handicapped, the elderly, unmarried mothers, families in difficulties of various kinds, and to the social aspects of care and after-care under the National Health Service Acts. The needs of individuals or families are not constant, and may at different times be in different categories. The proportion requiring the most skilled help is expected to be higher among the mentally ill and in certain family problems, than among the elderly or physically handicapped. (Paragraph 562.)

26. No information exists on which to base an estimate of the proportion in any service likely to fall into each category, or to make an overall estimate. Such estimates are essential to sound decisions about appropriate staffing and

deployment of staff. The absence of data on this and other matters mentioned throughout the Report points to the need for more substantial research and inquiry than has hitherto been undertaken. We **recommend** a variety of studies to determine types of need and appropriate ways of meeting them. (Paragraph 563.)

27. To meet the three gradations of need, we propose the employment of a new grade of worker, and of two types of social worker trained in different ways. To give straightforward help we **recommend** a new worker with a short but systematically planned in-service training, for whom we propose the name ' welfare assistant.' Such workers would relieve trained and experienced staff of a proportion of the simpler work and straightforward visiting. They should work under the direct supervision of trained social workers, and should themselves be trained to recognise indications that more skilled help or a different service is required. (Paragraphs 567–574, 703–705.)

28. To meet the second and third types of need we **recommend**

(1) social workers with a general training in social work equivalent to two years full-time training. These workers would provide help with the more complex problems which form the greater part of the social work required in health and welfare departments. Much of this work demands a higher level of skill and insight than the untrained worker, or the worker without adequate training in social work, can be expected to have :

(2) professionally trained and experienced social workers to undertake casework in problems of special difficulty. These workers, such as psychiatric social workers, almoners and family caseworkers, should have a professional training in social work following a social science or other related qualification. When they have gained sufficient experience after qualifying they should normally be used

(*a*) to undertake initial interviews when the information available suggests there may be a particularly difficult problem, in order to assess the kind of help needed, and the willingness of the individual or family to receive it ;

(*b*) to act as advisers or consultants to other social workers in a range of services, and as supervisors (in the sense of teaching and guidance) of newly qualified or appointed social workers, and to assist with in-service training ;

(*c*) to provide a casework service for those needing the most skilled help with personal or family problems which are preventing them from making the best attainable social adjustment. (Paragraphs 575–601.)

Case records

29. Good social work records are needed in the health and welfare services: at present these are often inadequate. We **recommend** that efforts should be made to encourage better case recording, and to establish procedures for making relevant information available when necessary to other departments and professional colleagues. Special care is necessary in safeguarding confidential information. We **recommend** that attention should be given to this on the lines suggested in the body of the Report. (Paragraph 606.)

Specialisation: the place for a 'general purpose social worker'

30. Existing specialisation in social work in the health and welfare services is partly a result of piecemeal historical development, and partly of a division along the lines of physical or mental handicap. We do not think this type of sectionalisation provides the best service. The focus in social work should be on the social and personal needs of the individual or family, rather than a particular aspect of the problem. In our view less specialised functions would provide a better service and make more profitable use of the resources available. (Paragraphs 639–653.)

31. The term 'general purpose social worker' has caused much confusion which its continued use will only perpetuate. We have been unable to suggest an alternative in view of the variety of nomenclature already in use. We hope that as an increasing number of trained social workers become available the title of 'qualified social worker' alone may prove sufficient and will be used only for those with one or other of the qualifications we recommend. This would be in line with existing practice for occupational therapists and health visitors. For the purpose of this Report we take a 'general purpose' social worker to mean a trained worker who is employed to undertake a range of duties in the health and welfare services.

(Paragraphs 654–655.)

32. The evidence in favour of a worker of this kind distinguished three categories within the total social work function, broadly comparable to the three types of worker identified above. The most widespread objection to any combination of existing functions was the range and complexity of the problems to be met. This objection would be less significant if a general training in social work were available nationally, and if it were accepted that some situations can only be dealt with by professionally trained and experienced social workers. If these requirements—the necessity for training and for a casework service—can be satisfied, an officer corresponding to the present area or district welfare officer or the mental welfare officer could fulfil a range of functions in the health and welfare services. We **recommend** accordingly that (provided an adequate training is available) local authorities should consider a broader grouping of social work functions. In practice many officers would not cover the full range of services, except possibly in some rural areas, because there would be a natural grouping of services according to local administrative arrangements and circumstances. But all would have shared a common training, followed later by such additional preparation as might be needed for specific work. We exclude duties in connection with the registration of births, marriages and deaths which we do not regard as an appropriate function for trained social workers.

(Paragraphs 657–664.)

33. With the training we recommend, and given experience in the local authority service, the advice and help of professionally trained and experienced social workers, and the contribution and support of complementary services, individual officers should be able to carry a varied case load. This should result in a more economical and efficient service. Similarly, the departments concerned should have available to them such special advice and consultation as might be required in individual cases, as, for example, psychiatric consultation, or the services of an officer fluent in communication with the deaf. (Paragraph 665.)

Patterns of future development

34. Provided a general training in social work is available, we **recommend** that the functions of social workers in the health and welfare services should be classified as follows:—

(1) Officers with a general training in social work should undertake the main range of such work in health and welfare departments, that is most of the work at present undertaken by welfare officers, visitors to the handicapped, home teachers of the blind and workers with the deaf, mental welfare officers and other social workers in health departments concerned with family problems and the social aspects of the after-care service. It would be for local authorities to determine the extent to which they wished to combine these functions for social work purposes.

(2) Professionally trained and experienced social workers should provide a casework service and generally advise and help other staff in dealing with difficult cases in a range of services. They should supervise newly qualified or appointed social workers and assist with in-service training. In due time we hope that persons with similar qualifications in group work and community organisation will also be available.

35. In addition, welfare assistants with an in-service training should be available to all social work staff in welfare departments, and in health departments to all workers concerned with the needs of individuals and families.

(Paragraphs 666–731.)

36. These proposals would be related to the existing structure of the service in the following way.

Officers with a general training in social work

37. The function of these officers is to provide systematic help to people with more complex problems requiring such help from a trained worker. On first appointment they should be under the supervision of an experienced or more highly qualified officer, and should subsequently have opportunities for refresher courses or advanced training.

The mental health service

38. A considerable expansion and development of the local authority mental health service must be expected; it will usually constitute one of the main groupings of services. Mental welfare officers should take the general training in social work recommended, in common with other social workers, but with an emphasis on mental health. They would either undertake the full range of mental health duties, or those most suited to their personality, training and experience, and to the administrative needs of the service. They should be interchangeable within the mental health service, and equipped, by virtue of their general training, for social work in other health services and under the National Assistance Act.

39. The employment of mental welfare officers solely to undertake the statutory procedures of certification and removal is not in the best interests of the mentally ill; we see no convincing argument for a separate mental deficiency service. Mental welfare officers should co-operate with the supervisory staff of occupation centres especially in regard to home visiting. Their advice on mental health matters should be available to other staff:

they themselves should have access to psychiatric and casework consultation and advice. In authorities where these facilities are not available mental welfare officers should, wherever possible, be able to consult a hospital psychiatrist or psychiatric social worker. In hostels for the mentally disordered in the community, they (and psychiatric social workers) should be available to advise and help residential staff and residents as required.

40. We have been impressed by the benefit to the mentally ill, in continuity of care and in the quality of the service given, when there is real teamwork between the staff of local authorities and mental hospitals. Joint use of staff helps to promote easy and effective co-operation, and we **recommend** that such arrangements should be encouraged. (Paragraphs 668–673, 710–712.)

Services for the care and after-care of the sick

41. This grouping includes the tuberculosis service, the after-care of patients referred for social work by hospitals or general practitioners, and the venereal disease service. An expansion and development of some of these services is likely to be required. Depending on the extent of development in any given authority, officers with a general training should either be employed exclusively in after-care, or (preferably in our view) undertake these duties as part of a more general case load. They should have medical consultation, and casework advice from professionally trained and experienced social workers whenever possible. They should be closely associated with the work of health visitors and other health workers.
(Paragraphs 674, 713.)

Social work with families

42. There are already signs of a general expansion of this work which we welcome. This grouping of services includes social work with a range of family problems including homelessness, neglect or ill treatment of children, the 'problem' family and unmarried or unsupported mothers who require such help. A general social worker is particularly appropriate because of the variety of needs, and the different ways in which these may arise. Officers with a general training in social work in either health or welfare departments should help such families and co-operate with all other workers with responsibilities in this field. (Paragraphs 675–676, 714–716.)

The home help service

43. The home help service is an essential complement to the health and welfare services with which we are concerned and makes a significant contribution in each gradation of need among those requiring help from social workers. In some areas it has developed into a social service of considerable importance. Officers with a general training in social work, and with administrative ability and experience in staff management, should be eligible for appointment as organisers or deputies. Close co-operation with workers in related services is essential. (Paragraphs 677–678, 717.)

Domiciliary and residential care of the elderly

44. There is room for improvement in the early discovery of the needs of the elderly, and in the development and integration of statutory and voluntary effort for older people. Officers with a general training, whether employed

in health or welfare departments, will be in a position to see that an adequate service is provided. They should work closely with health visitors and other health workers, general practitioners, housing authorities and a range of voluntary organisations and individual voluntary workers. Some of this work will, as now, form part of the duties of welfare officers in receiving and investigating applications for residential care but it will often be mainly required to ensure that the domiciliary services are fully utilised, and in relation to voluntary services grant aided by the local authority.

45. The increasing infirmity of old people coming into residential care casts a heavy burden on residential staff. We commend the existing training facilities for these workers, and make suggestions for the future. Social workers who are otherwise eligible might be considered for certain residential posts. There is a need for visiting officers who will help staff and residents with difficult or special problems. Such work does not normally require a special appointment and should form part of the duties of welfare officers.

(Paragraphs 679–681, 718–719.)

Services for the handicapped

46. These constitute a natural grouping, though each service has distinct aspects.

(a) *The blind and partially sighted*

The blind need special help in accepting and overcoming the effects of their disability, a need shared in common with others who suffer from severe handicaps. The present standard of service, which owes much to voluntary effort, must be maintained and still further improved. Advantage should also be taken of new developments or methods and of training experience in related fields. Efforts must be made to build up services for the partially sighted. The majority of blind people are now over pensionable age. Evidence showed that only a small proportion of the time of home teachers of the blind is spent on teaching braille, moon or handicrafts. It is therefore uneconomic for the blind to be cared for only by workers whose training is mainly in subjects useful to a small minority of blind people. This should be recognised, though it would be for local decision whether all workers with the blind should be qualified to teach braille or moon, or whether only a proportion should be so equipped. It is our considered opinion that the blind would benefit and thus the services be still further improved, if these were staffed by officers who had a general training in social work combined with added knowledge of the needs of the blind, and a wider experience in the related welfare services.

We therefore **recommend** a variety of experiment in widening the functions of home teachers, after appropriate further training, with a view to relating the work more closely to other welfare services while at the same time raising the standard of service to the blind. Some home teachers should be given the opportunity, and encouraged, to take the general training we recommend. Successful completion might or might not lead to a change of duties but it would confer eligibility for appointment as a welfare officer with a wider range of function, and thus improve promotion prospects. Workers with

the blind who possess qualifications or aptitude in craft teaching should continue to provide this service, but eventually it might become part of an occupational therapy and craft teaching service for the health and welfare services as a whole.

(Paragraphs 683–690, 720–721.)

(b) *The deaf and hard-of-hearing*

There are unique difficulties in communicating with the deaf. We are disturbed to see that the isolation which the nature of the handicap imposes is further accentuated by the complete specialisation of the service. We **recommend** further research and experiment into the needs of the deaf and into ways of bringing them more closely in touch with the community. Local authorities should take a more active interest in this work, and experiment in ways of bringing about an adequate service. It is not practicable to suggest that all local authority welfare officers should acquire real fluency in communication with the deaf but a proportion should be able, either in the course of the general training or subsequently, to learn to make adequate contact with those deaf people for whose welfare they are responsible.

Where greater understanding or fluency is required, local authorities should continue to use officers of voluntary organisations, or employ their own trained or experienced staff for this purpose. The aim should be to establish a high standard of service, and to make use of special knowledge and skill without establishing a separate service. Efforts should be made to provide a casework service, even if this must be attempted at first through an interpreter.

Clubs and other social activities play an important part in the life of deaf people. Local authorities should increasingly provide these themselves or in co-operation with the voluntary organisations. They should not take over responsibility for spiritual ministration, though they should see that it is available. They should continue to support the activities of the voluntary associations for the hard-of-hearing. Such services as may be required by this group should be provided by officers with a general training in social work.

(Paragraphs 691–694, 722.)

(c) *The general classes of handicapped persons*

Social work services for the general classes of handicapped persons should primarily be provided by officers with a general training in social work and should be closely related to work with the blind and deaf and, when appropriate, to that for the chronic sick at home. We regard the functions of occupational therapists and social workers as complementary. Where officers with a general training have aptitude for craft work they should be able to improve their skill, both in the craft itself and in teaching, so as to include these functions among their other duties. Ability to teach crafts should not, however, be regarded as a necessary skill for social workers with the handicapped.

(Paragraphs 695–697, 723.)

Social casework advisers, consultants or supervisors in a range of services

47. The functions of these social caseworkers are to be responsible for the more difficult casework, to advise other staff in a range of services, to supervise newly qualified social workers and assist with in-service training. They should operate throughout the health and welfare services in addition to undertaking casework, and should be freely consulted on all problems requiring casework help. These officers will normally have a high proportion of the more difficult cases in their case loads, in addition to responsibility for advising other staff. Because these functions require considerable skill we **recommend** that a proportion of posts should have senior status. The need for these workers is not limited by the size of the authority. We suggest that authorities having such staff might consider offering an advisory casework service to a neighbouring authority.

48. In the services under review, psychiatric social workers are primarily engaged in the mental health service: they should have psychiatric consultation and should themselves provide casework consultation for mental welfare officers. Almoners (medical social workers) in the local health authority will continue to be concerned with the tuberculous and the after-care of patients referred for social work by hospitals, general practitioners, medical officers and other health workers. They should have medical consultation and should themselves be used generally on problems requiring casework help. There is wide scope for family caseworkers as social work services for families become more widely developed.

(Paragraphs 698–702, 724–728.)

Welfare assistants

49. The function of welfare assistants is to relieve trained social workers of straightforward visiting and other duties in order that their skill may be used to greater advantage. Welfare assistants should be carefully selected and should not undertake initial or other visiting for the purpose of assessing need. They are more likely to be used in work with the elderly and handicapped than, for instance, with the mentally ill or unmarried mothers. They could play a part in the home help service, and might also visit mental defectives where the home situation was relatively stable. They could assist generally in social and craft centres and occupation centres. There would be less direct scope for them in work with families, or in the after-care of the tuberculous, except in carrying out straightforward work for the trained social worker in charge of the case.

50. We **recommend** that welfare assistants should be employed only where the planned and continuing in-service training which we propose can be provided. They should always be attached to and work under the supervision of qualified social workers. (Paragraphs 729–730.)

RECRUITMENT AND CAREER PROSPECTS

51. There is an extreme shortage of trained social workers in the health and welfare services. Recruitment is also inadequate. More than 40 per cent of officers are over 50 years of age, and an unusually high retirement rate must be anticipated during the next 10 years at a time when many of the services will be faced with the necessity for expansion to meet fresh

demands. In addition to making the most effective and economical use of staff, steps must be taken to improve recruitment. (Paragraphs 732–735.)

Problems of recruitment

52. A fundamental difficulty is that social work in the health and welfare services is an unrecognised career. There is an urgent need to bring the value and interest of such work to the notice of existing and potential social workers. Every means should be taken by publicity of all kinds, by employee and professional associations, and by central and local government to emphasise the scope and challenge of social work in this setting. It is particularly important that grammar schools should be aware of social work as a profession, and of the nature of the work in the health and welfare as well as other services. We **recommend** that, as soon as a training programme can absorb additional students, the possibility of a national campaign to recruit candidates for social work should be explored. It should be planned to correspond with the period when the greater numbers of young people resulting from the post war population 'bulge' are still available. (Paragraphs 736–739.)

53. Potential recruits to the health and welfare services are attracted elsewhere, often to industry or commerce, by facilities offered for further education and training. Better publicity would help to ensure that the possibilities of a career in these services were better known, but comparable training opportunities and the assurance of reasonable salaries and career prospects must also be offered. (Paragraph 740.)

54. There is a general lack of promotion prospects for some officers and this results in a vicious circle in which it is difficult to attract trained social workers, yet the position cannot be substantially improved until more trained workers are available, and are employed to the best advantage. (Paragraph 741.)

55. Experience suggests that posts which offer opportunities for a range of social casework attract more and better candidates, and give better career prospects than can be expected in a narrowly specialised field. Our proposals, already outlined, for a broader grouping of functions should favourably affect recruitment, while being sufficiently flexible to allow for special interests. (Paragraph 742.)

56. Lack of a recognised training and qualification for welfare officers and mental welfare officers gravely affects recruitment. The health and welfare services are also at a disadvantage in comparison with the child care and probation services in which financial assistance is available to candidates accepted for training. We make recommendations to remedy both deficiencies. (Paragraph 743.)

Recruitment of professionally trained social workers

57. Psychiatric social workers and almoners are attracted to hospitals and child guidance clinics rather than to the local authority health and welfare services, partly because their professional status and function is more clearly defined in the former settings. They, and family caseworkers, would better appreciate the scope of a career in the health and welfare services if they had practical experience of the work during training. We think the difficulties of providing this have been too readily accepted. (Paragraph 744.)

58. Lack of recognition of function, and of full integration with the work of a department, is also a deterrent to recruitment. These social workers are in short supply and will not easily be attracted to the services if their functions are more fully recognised elsewhere. Senior administrative officers and others should understand the contribution of trained caseworkers, and their methods of work. Professionally trained workers on their part should accept the obligation to operate within the statutory framework and local policy of the services, and appreciate the necessity for administrative skill. Mutual understanding on these matters is fundamental to improved recruitment. (Paragraph 745.)

59. We have suggested ways in which these social workers should be used. In view of the importance of the functions outlined, both in relation to the needs of those using the services and the general quality of the local authority services, we have recommended the establishment of advisory, consultant and teaching posts in both health and welfare services. (Paragraph 746.)

Use of the terms 'psychiatric social worker' and 'almoner' or 'medical social worker'

60. We **recommend** that the term 'psychiatric social worker' should be restricted to persons holding a university mental health certificate (or who are eligible for membership of the Association of Psychiatric Social Workers), and the term 'almoner' or 'medical social worker' to persons registered with the Institute of Almoners. (Paragraph 747.)

Career prospects

61. Much of the evidence drew attention to the importance of adequate career prospects, and the need to attract more men to the health (especially the mental health) and welfare services. In view of the responsibilities carried by many of these officers and the small number of senior posts at present available we **recommend** that authorities should consider the further establishment of such posts, particularly in the mental health service. (Paragraph 748.)

62. We **recommend** that where the National Assistance Act services are separately administered these should be under the direction of a chief welfare officer trained and experienced in social work and administration. In those authorities where these functions are carried out in the department of the medical officer of health, or the county or town clerk, responsibility to the council and general oversight of the service rests with the chief officer. The day to day administration of the services should be the responsibility of a senior welfare officer, whose qualifications, salary and status should be similar to those of a chief welfare officer having direct responsibility to councils of authorities of comparable size. (Paragraphs 749–750.)

63. We are of the opinion that social work services should be administered by trained officers with both administrative and field work experience. Every opportunity should therefore be given to suitable field workers to acquire experience in administration, and thus, if they wish, to become eligible for administrative positions. The size and administrative structure of any given authority, and the grouping of services, affects promotion prospects in that authority. (Paragraph 751.)

64. New recruits with a general training in social work will normally be appointed as field workers to health and welfare departments. They should be eligible for promotion to district, area, or divisional officer, or a similar post combining administrative and field work duties, and subsequently, if they wish to pursue an administrative career in the welfare department, to deputy or chief officer appointments. In the health department the comparable senior post would be that of senior officer in charge of the social work services. It should be open to selected officers to apply for professional social work training, and recognition should be given to successful completion of such training. They might be considered, for purposes of status and salary, as being on a par with colleagues on the administrative side above the post of district or divisional officer. New recruits with a social science qualification should take the additional training recommended, in order that their careers may follow similar patterns. (Paragraphs 752–753.)

65. Professionally trained social workers should enter the services initially as field workers, and later qualify for advisory, supervisory and consultant positions. Promotion to administrative responsibility, when suitable and if desired, should be through the key position of area or divisional officer or equivalent, and subsequently with the same prospects as other officers. Social workers with either professional or general training in social work who prefer to remain field workers should have due recognition of their experience in terms of status and length of salary scale. (Paragraph 754.)

66. A proportion of welfare assistants with in-service training will wish to take further training. If they have the necessary educational and other qualifications, they should be encouraged to apply either for a professional or general training in social work. On successfully completing a training course they would be eligible for promotion on the lines described above, with the same opportunities as other staff. Those who remain as welfare assistants throughout their service should receive some financial recognition of experience in the length of the incremental scale. We do not anticipate that welfare assistants would qualify for the administrative, professional and technical salary scales of the appropriate National Joint Councils for local authority services. (Paragraph 755.)

Salaries

67. The salaries of social workers are influenced by the early development of the services, when a large number of those undertaking social work were untrained or employed by charitable organisations with limited resources. The salary paid should be such that those who choose this way of serving their fellow men should not be at a disadvantage compared with those who choose other opportunities for service. (Paragraph 756.)

68. Existing salary scales offer no incentive to certain officers to take a professional social work training. The scales applicable under National Joint Councils' administrative, professional and technical scales may result in professionally trained social workers being paid on a lower scale than some officers without such training. In addition, Whitley scales based primarily on the hospital service also compare unfavourably in certain respects. There is thus no financial inducement to local authority officers to apply for professional training, or to professionally trained social workers to enter local government employment. We **recommend** that these anomalies

should be resolved and that salary scales should be so revised and graded as to be commensurate with the training required of professionally qualified workers, and the degree of responsibility demanded of them. When career prospects are limited by the size of a department or authority, a longer salary scale with a higher maximum would allow for recognition of experience. (Paragraphs 757–758.)

Sources of recruitment

69. The implementation of our recommendations in general should stimulate recruitment to both health and welfare services. We expect an increase in recruits from present sources and also from other suitable candidates, once it is known that facilities for training are available. (Paragraph 759.)

70. Married women make a valuable contribution to the services provided that their home commitments do not prevent them from carrying a fair share of the work. They should be eligible for the general training we recommend, or for appointment as welfare assistants. (Paragraphs 760–761.)

71. We think that there could be a substantial increase in the employment of part-time officers (including married women) especially in work where constant availability is not an over-riding consideration. Greater use might be made of professionally qualified and experienced caseworkers in this way. (Paragraph 762.)

72. Recruitment may sometimes be hampered by too definite an assumption that women are appropriate for some kinds of work and men for others. We suggest that local authorities might reconsider their views on this matter. (Paragraph 763.)

73. Some local authorities may wish to consider the recruitment of trained mental or mental deficiency nurses to the mental health service, though we do not anticipate that a great number would become available in this way. Such candidates would require training in social work. (Paragraph 764.)

74. Voluntary workers play a supplementary but essential part in the statutory health and welfare services but their recruitment cannot be expected to solve manpower problems. (Paragraph 765.)

Economy in manpower

75. Log books kept by a number of officers within our terms of reference showed about 20 per cent of working time spent in travel. We **recommend** that local authorities who do not provide official transport should examine working conditions so as to determine whether, by making arrangements for the use of their own or official cars, the services of social workers might be used more economically and to greater advantage. (Paragraphs 766–767.)

76. A number of these officers spent nearly 50 per cent of their working time in letter writing, record keeping and other office work. Many had no clerical assistance. We **recommend** that adequate clerical assistance and telephone facilities should be available: facilities for confidential interviews are also required. (Paragraphs 768–769.)

The size of the problem

77. We have considered how the size of the problem in the health and welfare services might be estimated. The need for social work help is

frequently made apparent through the demand for other services, and this adds to the difficulty of estimating its extent in any precise way. Even approximate totals of those in the various categories with which we are concerned are rarely known and difficult to ascertain. There is at present no method of telling what proportion in each category is likely to need social work help, or for how long. The overlap between some categories is likely to be quite large.

78. Our conclusion is that no reliable estimate of the size of the problem or of any portion of it is possible at present. We have thus been constrained to estimate future staffing needs in the absence of certain basic data. We hope that research to provide this data will soon be undertaken in sample areas. (Paragraphs 770–775.)

Case loads

79. We have not found it possible to attempt to lay down figures for optimum or even maximum case loads, though both will become of increasing importance as the social work services expand and trained staff become available, and as more emphasis is laid on preventive work. The criteria by which case loads can be determined depends on detailed and systematic study of a kind which has yet to be undertaken in the social services. We **recommend** that studies should be undertaken in the health and welfare services, preferably as part of the larger inquiry already recommended. (Paragraphs 776–780.)

Estimates of numbers of social workers required

80. Our estimates are based on the assumption that everything possible has been done to economise in the use of staff. They are related to the development of the services over a 10-year period. Estimates are given separately for the three categories of officer which we have distinguished. (Paragraph 781.)

(i) *Officers with a general training in social work*

81. We envisage that the main range of social work in health and welfare departments will be undertaken in future by officers who have taken the general training in social work which we recommend. In the estimates that follow we consider separately the needs of various services, but do not imply that these will in fact be separately staffed. This would be contrary to our earlier recommendations. (Paragraph 782.)

82. For services under the National Health Service Acts we estimate the requirements of the mental health services at the equivalent of 2,200 whole-time officers (an increase of 1,100) : of the care and after-care services, at the equivalent of 200 whole-time officers (an increase of 120): and of social work services for families, at the equivalent of 200 whole-time officers (an increase of 185). In the home help services we see a need for 200 officers with the general training in social work. (Paragraphs 783–788.)

83. For services under the National Assistance Act, 1948, (excluding those for the blind, the deaf and the general classes of the handicapped) we estimate requirements at the equivalent of 1,100 whole-time officers (an increase of 200): for services for the blind at the equivalent of 900 to 1,000 whole-time officers (an increase of 100 to 200): for services for the deaf at the equivalent

of 150 to 200 whole-time officers (an increase of 140 to 190) and for services for general classes of the handicapped at a minimum of 600 whole-time officers (an increase of 350). (Paragraphs 789–796.)

84. We accordingly estimate the total requirements of officers with the general training in social work at the equivalent of 5,550 to 5,700 whole-time officers (an increase of 2,395 to 2,545 over present figures). We **recommend** that these numbers should be reached over a period of 10 years and estimate annual recruitment, to enable this increase to be made, at 240 to 255. In addition, taking into account the age distribution of existing officers, we estimate recruitment to make good losses by retirement each year at 260. (Paragraphs 797–801, Table 28.)

(ii) *Officers with a professional training in social work*

85. In view of earlier recommendations that these officers should undertake casework in their own and other settings we think there should be some flexibility as between groups, provided the overall estimate is retained. Subject to this we estimate the requirements of the health and welfare services for psychiatric social workers at the equivalent of 300 whole-time officers (an increase of 270) and for almoners at the equivalent of 300 whole-time officers (an increase of 230). It is particularly difficult to forecast the numbers of family caseworkers which will be required, but provisionally we estimate these at the equivalent of 200 whole-time officers. We **recommend** that the overall figure of 800 should be reached within 10 years. We estimate the necessary annual recruitment to meet anticipated needs, including retirement, at 105. (Paragraphs 802–810.)

(iii) *Welfare assistants*

86. As soon as planned in-service training is available, it seems to us that at least 200 welfare assistants should be recruited annually for five years. Experience should then make it possible to estimate further requirements. We do not feel able at present to make an estimate of the numbers which will ultimately be needed. (Paragraph 811.)

THE CASE FOR TRAINING AND OUR PROPOSALS

The present position

87. There was substantial agreement in the evidence that training is essential for social workers in the health and welfare services. It is also clear that the present services are limited by lack of appropriately trained staff. The vacuum created when the Poor Law Examinations Boards ceased to exist has not been filled. Training for mental welfare officers and welfare officers is especially urgently required. (Paragraphs 812–814.)

88. Training in social work is mainly provided by universities, or requires a university qualification. The present provision for social workers within our terms of reference is :—

(*a*) University social science degree, diploma or certificate courses. These provide a preparation for a professional training but are not in themselves a social work training, though they are frequently regarded as such. (Paragraphs 816–821.)

(*b*) Professional one-year courses in mental health, medical social work and generic casework (applied social studies). (Paragraphs 822–827.)

(*c*) *Ad hoc* specialist courses provided by voluntary organisations for work in specific fields. (Paragraphs 828–836.)

(*d*) In-service training and a variety of refresher and other courses. (Paragraphs 837–841.)

89. Comparison with certain other public services employing social workers shows that those in health and welfare departments are less favourably placed in regard to qualifications, training facilities, and financial assistance for training. Eighty-nine per cent of officers have no qualification in social science or in professional social work. Substantial efforts have been made by voluntary organisations to provide training in certain fields but such efforts have been limited by the resources available. There is little systematically planned in-service training, while release to take a recognised training in social work is rare. (Paragraphs 842–857.)

90. The demands made on the health and welfare services require adequately trained and experienced staff. Some of the suggestions for training put to us in evidence were, in our opinion, either unrealistic or inappropriate. In our view the type of training required is related to the degree of skill needed by the three types of worker which we recommend. (Paragraphs 858–865.)

91. Very rapid advances have been made in the social and behavioural sciences which make it possible to provide a standard of service above that which was previously possible. A body of knowledge now exists which individual workers cannot acquire by experience alone, while social work practice now rests upon a systematic method and principles of work for which individual workers need training. (Paragraphs 866–867.)

Our proposals

92. We **recommend** two types of social work training for the two types of social worker.

(*a*) University social science courses followed by professional courses on the lines of existing training for psychiatric social workers, almoners and generic caseworkers. These university and other related professional courses provide the highest social work qualification at the present time.

(*b*) A new general training in social work outside the universities lasting for two years full-time (or 2–3 years part-time and one year full-time) leading to a national qualification of sufficient standing to be recognised by the Local Government Examinations Board and the National Joint Councils as qualifying for certain appointments, promotion, and appropriate salary grading on administrative, professional and technical salary scales. We envisage that this training would be provided mainly in colleges of further education.

In addition, we **recommend** systematic in-service training for welfare assistants. Various short courses and refresher courses are also required for all workers. (Paragraphs 868–872.)

A National Council for Social Work Training

93. A national qualification in social work calls for the provision of training on a national scale. We **recommend** that a National Council for Social Work Training should be set up with the following functions:—

(*a*) To secure the provision of, and to recognise, a sufficient number of training courses of the desired standard in order to prepare students for the national qualification, and to co-operate with local authorities and other employing bodies in providing field work training of the necessary standard.

(*b*) To have an overall responsibility for the nature and standard of the tests for the qualifying award, to be known as the National Certificate in Social Work, and to make the award.

(*c*) To co-operate with universities and other organisations concerned with the provision of professional courses in social work.

(*d*) To sponsor and assist with refresher courses of all kinds, including advanced courses and courses in supervision and social work teaching.

(*e*) To conduct publicity for recruitment.

(*f*) To assist in the selection of students.

(*g*) To assist local authorities with in-service training, including courses for welfare assistants.

(*h*) To facilitate the production of teaching materials, for example case records.

The National Council for Social Work Training should be an independent representative body, with its own premises and staff and financed from public funds. This we regard as essential if it is to function effectively. It is also in line with current practice in relation to the training of certain other workers for the public services. (Paragraphs 873–878.)

94. We **recommend** that any legislation required to establish and finance this Council should be introduced as soon as possible. (Paragraph 879.)

95. A small executive committee and a professional board may be necessary to take responsibility for detailed organisation and educational activities within the general lines of policy laid down by the National Council. (Paragraph 880.)

The relation between the National Council for Social Work Training and the universities

96. We hope universities will be prepared to take an active part in the work of the National Council, and to consult with it about the training and employment of students taking the appropriate university courses. In view of the shortage of such workers we hope that universities will do everything possible to increase the numbers taking social science courses followed by professional training. (Paragraphs 882–883.)

The relation between the National Council for Social Work Training and other educational establishments

97. The National Council should take the initiative in requesting suitable educational establishments to run courses. In the early stages, when both social work teachers and supervisors are scarce, the National Council might lend staff to assist with local courses. (Paragraph 884.)

The National Council and possible regional arrangements

98. National planning and support is essential in establishing these new training courses. Close connection between universities, other educational establishments and employing authorities is also desirable, and might be facilitated by local or regional arrangements in co-operation with the National Council for Social Work Training. (Paragraph 885.)

The contribution of local authorities and others in the proposed training programme

99. The Council should discuss with local authorities, regional hospital boards and other agencies the action required to provide essential facilities for practical training. We do not minimise the demand which these plans will make on certain local authorities in terms of staff time, accommodation for students, and other ancillary services. The contribution of local authorities is a vital element in providing the necessary field training. We were greatly heartened therefore to find that the local authority associations took the view that the obligation to provide teaching facilities in the field for a variety of professional students is well recognised. To provide similar facilities for social workers going into the health and welfare services would thus simply be an extension of accepted practice. In view of the fact that substantial supervised field work is an integral part of training for social work, we **recommend** that the central government departments concerned should request local authorities and regional hospital boards to consider giving a high priority to providing facilities of the required standard for students taking a recognised training for social work under either university or other auspices. We hope that voluntary organisations will also be prepared to provide adequate facilities as required. (Paragraphs 886–888.)

General training leading to the National Certificate in Social Work

100. These courses in social work will be a pioneer venture. They should be provided in colleges of further education or other educational establishments, with the co-operation of the universities and employing authorities. (Paragraph 889.)

Admission requirements

101. Selection of students should be on the basis of personal suitability, as well as appropriate educational qualifications, age and experience. (Paragraph 890.)

The content of the courses

102. The courses should be a combination of study and supervised practice. We make suggestions in the body of the Report for the theoretical and field work content of the syllabus. (Paragraph 891.)

Specialisation and training

103. We **recommend** that the general training should also provide opportunity for more detailed study of some given aspects in line with a particular student's bent. Those interested in work with the blind or deaf, or in mental health should, for example, have more substantial theoretical study of these subjects during the course, as well as field work placements in the services concerned. Facilities to carry knowledge and skill to a more advanced level, whether of experience or training, should be available subsequently. It is our hope

that the National Association for Mental Health, and the organisations which now train and examine those who wish to work with the blind or deaf, will be prepared to co-operate in the general training courses, where their knowledge and experience will have much to contribute. (Paragraphs 892–896.)

Length of the general training courses

104. The necessary ground cannot be covered in less than two years full-time, or two to three years part-time followed by one year full-time. The courses should be taken in two parts. Part I should be taken either by one year of full-time study, or by two or three years of part-time study. The final year of study for Part II and the award of the Certificate should be full-time. (Paragraphs 897–902.)

Assessment for the National Certificate in Social Work

105. The award for Part I might be entitled the Intermediate Certificate in Social Work, and for Part II the full National Certificate in Social Work. We hope the training would be of a sufficient standard to enable universities to consider admitting individual candidates who had successfully completed it to university one year professional courses with a minimum of additional academic preparation. (Paragraphs 903–904.)

Suggestions for meeting the shortage of supervisors

106. The shortage of qualified social workers able to undertake field teaching is a major limiting factor in any rapid expansion. One of the first essentials is to attract officers qualified to act as supervisors into local authority health and welfare departments. Such appointments should be made in conjunction with training courses. Consideration should also be given to part-time appointments. We also **recommend** that local health and welfare authorities should pursue a vigorous policy of recruiting officers who have recently completed a professional training who may become supervisors when they have had sufficient experience. (Paragraphs 907–910.)

Short-term and long-term plans

107. The first task of the National Council for Social Work Training would be to work out an overall training plan, so that the short-term arrangements required in the present urgent situation should dovetail with and lead into long-term plans. (Paragraphs 911–913.)

108. We **recommend** that a high priority should be given to the release of mental welfare officers and duly authorised officers to take the general training in social work. We regard the training of welfare officers as hardly less urgent. Every effort should be made to attract new recruits to take the two year course. (Paragraph 914.)

109. In addition we **recommend** emergency training for specially selected officers at present in the services to take a one year full-time course leading, on successful completion, to the award of the National Certificate in Social Work. This course, which should be distinct from others recognised by the Council, should be planned and staffed for the purpose. It would be designed to meet an urgent need and should on no account run for more than five years. (Paragraph 915.)

110. High priority should also be given to conferences or refresher courses for senior officers and for officers selected as supervisors and teachers, both in the general training courses and for in-service training. (Paragraph 916.)

Provision of part-time two year courses

111. We envisage that it should be possible with the full co-operation of everyone concerned to start 3 two year part-time courses fairly quickly and a further 4 to 6 while the earlier courses are in their second year. These should be day-release courses, with two residential (or whole-time) weeks a year, and with an annual intake of 15 students. Various imaginative devices are required to meet the needs of rural areas, which present special problems. We would see a necessary place, both in short-term and long-term plans, for residential as well as day-release courses. These should be open only to candidates who are not within reach of a day-release part-time course.

(Paragraphs 918–921.)

Provision of full-time two year courses

112. We think it essential that full-time courses for the Certificate in Social Work should be started as soon as possible. Given adequate facilities for field teaching, we would hope that about 15–20 students could be accepted each year. We **recommend** that a pioneer full-time two year course should be started under the best possible auspices without delay. (Paragraph 922.)

Training proposals for officers already in the services

113. We **recommend** that officers in the health and welfare services without a social work training, and over the age of 50 or with 15 or more years experience in a social work appointment, should be recognised as qualified by experience. Many should be encouraged to take the appropriate refresher courses. Other officers over 40, or with more than 5 years experience, should (unless they hold a social science qualification) take part-time courses for Part I of the National Certificate in Social Work ; they should be eligible to take Part II, if so desired, and should be eligible for promotion even though they do not hold the full Certificate. Officers aged under 40, or with less than 5 years experience should (unless they hold a social science qualification) take Part I by part-time or full-time study, and go on to take Part II (full-time) : selected officers should be given leave of absence to take a university or other professional course in social work. Officers in this group who hold a social science qualification would normally be expected to take a university or other professional course: if, however, they wished to qualify for the National Certificate in Social Work they should be regarded as having substantially fulfilled the requirements for Part I of the Certificate.

(Paragraphs 923–924.)

114. We estimate that 1,125 officers will be eligible to take courses for the National Certificate in Social Work, of whom 875 should take at least Part I, and 250 others should take the full Certificate. We hope that about 10 younger officers a year among the latter will be given leave of absence to take the two year full-time course, and about 15 a year to take the one year emergency course for the five years of its operation.

(Paragraphs 925–930, Table 33.)

Training proposals for new recruits

115. Normally new recruits to the services will be trained before appointment, or employed initially as welfare assistants and subsequently encouraged to take the full-time two year course for the Certificate. New recruits with a social science qualification should take either a one year university or other professional course, or a one year full-time course for Part II of the Certificate. (Paragraph 931.)

116. Training facilities for full-time two year courses will be needed for an annual intake of about 540 students for the first year (Part I), and for about 570 in the second year (Part II). This requires about thirty full-time courses for the country as a whole. It should be possible to make provision within about seven years for the number of students we envisage. (Paragraphs 932–934.)

Financial assistance for training

117. Adequate inducement must be given to local authorities to release for training officers whose services can ill be spared, and also to encourage such officers to apply for training. We do not think that existing provision, however generously applied, will suffice for training on the increased scale which we recommend. Additional provision of assured grant aid is essential. We **recommend,** therefore, that grant aid from central government funds should be available to individuals for training in social work in the health and welfare services, as it is already for those who intend to enter the probation or child care services. We understand that legislation will be required to enable Exchequer funds to be employed to finance training and refresher courses, and to grant aid students accepted for the general training, for a university social science course or university or other professional training, or to take refresher or advanced courses. We **recommend** accordingly as a matter of urgency that legislation for these purposes should be introduced. In addition, potential students should be better informed than at present about the financial assistance available and how it can be obtained. (Paragraphs 935–938.)

118. We also **recommend,** as an inducement to officers and new entrants to apply for training, that some financial recognition should be given on successful completion of a recognised course. (Paragraph 939.)

In-service training

(a) *General*

119. Better provision of planned in-service training is required than exists at present. This would include attendance at refresher courses, conferences, lectures, discussion groups and certain case conferences. Greater use should be made of staff meetings, field work manuals, bulletins and a staff library as means of continuous in-service training. The National Council for Social Work Training should assist authorities in planning such training when desired, in addition to providing courses for staff supervisors. In-service training for new recruits is extremely important and should include a period of orientation to the work of the local authority. This is necessary for those who have had a professional training in social work as well as others. (Paragraphs 940–942.)

(b) *For Welfare Assistants*

120. We **recommend** a systematically planned training, lasting six to eight weeks, to be followed by supervision and further in-service training. Training should consist of (i) a short induction or orientation course, (ii) visiting in connection with a small case load, (iii) discussion classes, (iv) study of written material. (Paragraphs 943–945.)

Training for residential staff

121. Certain staff of residential accommodation should be encouraged to take existing courses, such as those organised by the National Old People's Welfare Council, and to attend suitable refresher or other courses. In time they should be eligible for any suitable training provided under the auspices of the National Council. (Paragraph 946.)

Refresher and other short courses

122. We see an important place for refresher courses of all kinds in which practising social workers would carry further their interest in some particular aspect of the work. Refresher courses are also necessary for married women with professional social work qualifications who wish to return to social work after some years absence. (Paragraphs 947–948.)

A national staff college

123. In order that effective action should be taken as soon as possible, we **recommend** that a national staff college should be established immediately. We hope that it would be financed, at any rate in the initial stages, by a charitable Trust. Apart from giving effect at the earlier stages to the work of the National Council for Social Work Training, by providing pioneer courses for selected officers in the services to act as a nucleus of supervisors in their own departments, such a college could provide a forum for discussion by senior administrators and others of social policy and planning, and of social work method. Some training activities would be discontinued or contracted as more widespread facilities became available under the National Council for Social Work Training. (Paragraphs 949–955.)

The need for research : financial assistance

124. We refer throughout the Report to many points at which no information is available. A limited amount of research is being undertaken but much more is needed. We **recommend** that legislation should be introduced to enable the appropriate government departments and local authorities to incur expense in conducting, or assisting other bodies to conduct, research of the kind to which we have drawn attention. (Paragraphs 956–957.)

CO-OPERATION AND CO-ORDINATION

Liaison with workers in related statutory services

125. There is a social element in many aspects of the health and welfare services besides those covered by our inquiry. There must at all times be close liaison between social workers and colleagues in related services, especially medical and nursing officers and occupational therapists.

Health visitors and home nurses

126. The functions of health visitors in providing health education and social advice inevitably bring them into contact with a variety of social problems.

Similarly social workers are frequently concerned with families where there is a health problem. These two field workers, each trained in different professional disciplines should complement each other, and should each know enough about the other's field to recognise the point at which referral is indicated. There is a necessary overlap of knowledge between health visitors and social workers. An overlap of function may also occur when social workers are either not available or are not adequately trained. Implementation of our training proposals should go a long way towards remedying the present confusion of function.

127. It is desirable that the training of health visitors should enable them to recognise the signs of social problems, to understand the functions of social workers, and to know when to refer cases to them. The health visitor is an essential member of the team, and a first line of defence in social action to promote the well-being of children, families, elderly or sick people. Professionally trained and experienced social workers should be available to advise individual health visitors (as well as social workers) on difficult cases, sometimes as a prelude to referral.

128. The home nurse is also well placed to recognise social needs. There are many problems in the home care of the sick with which both home nurses and social workers will be concerned, and where good co-operation is required. (Paragraphs 958–975.)

The medical profession

129. Many medical problems have a social aspect. More emphasis is now placed in the training of medical students on the significance of social factors in health and disease, and general practitioners will increasingly look for someone able to assist in this field. It is essential for social workers to keep the medical aspects in mind, and to ensure that the general practitioner is informed of social action affecting his patients.

130. There is room for better liaison between social workers and general practitioners throughout the health and welfare services, notably in connection with the elderly, the mentally and physically handicapped, the sick and those in need of the home help service. General practitioners should be invited to attend, or make their views available, at case conferences when their patients' problems are discussed.

131. The hospital consultant should be informed of social matters affecting patients or their families, normally through the medium of the hospital almoner or psychiatric social worker. Continuing liaison is required when hospital care is prolonged, and in relation to geriatric units. Close co-operation is essential in the care and after-care of the mentally ill.

132. In all authorities medical advice and guidance is available from the medical officer of health and his medical staff. The medical officer of health is responsible for all services under the National Health Service Acts: in a proportion of authorities he is also responsible for those under the National Assistance Act. There should be regular consultation between field workers and medical officers, particularly in the care of the severely handicapped child or adult, and in regard to the deaf. (Paragraphs 976–981.)

Children's departments

133. The experience of many children's departments suggests that the removal of children from their families might have been avoided by preventive casework at an early stage. Families showing early signs of tension, deterioration or breakdown should be known to the health and welfare services. In many instances co-ordinated and wise use of the available resources of these departments could prevent breakdown, or shorten the time for which a family has to be separated.

134. In all matters involving the care of children where there is risk of the family breaking up there must be a study of the situation between workers in the health or welfare and children's departments to assess the need, and to agree how it is to be met and on the function of each worker. The needs of the situation, rather than departmental boundaries, should be the determining factor in defining each worker's responsibility. (Paragraphs 982–986.)

Housing departments

135. Many clients of social workers in the health and welfare services either are, or wish to be, council tenants. Good liaison between housing and health and welfare departments is essential in the care of the elderly, the tuberculous, unmarried and unsupported mothers, the welfare of the handicapped, whenever families are in danger of eviction or in temporary accommodation, or when a housing application requires the support of the medical officer of health. A regular exchange of information between appropriate field workers will help to ensure that the right help is given in time, particularly in regard to older people who live alone or in unsuitable accommodation, or who must give up a council tenancy on admission to hospital or residential care. Because of their regular contact with a proportion of the elderly population, housing managers or their staff would appear to be essential members of local old people's welfare committees.

136. Living accommodation suitably adapted to individual needs is essential for certain groups of severely handicapped people—paraplegics, for example, or those with progressive nervous or muscular disease, and disabled housewives. Co-operation in structural adaptations to premises, and in the continuing care of such persons as require these, is an important element in liaison between housing departments and health or welfare services.

137. The value and importance of working closely together on family problems is obvious, especially if the family is in arrears with rent. Experience shows that co-ordinated action by housing, health or welfare departments, facilitated by direct contact between field workers, can reduce both the arrears and the demand for temporary accommodation.

138. The particular difficulties of many unmarried and unsupported mothers and their children in obtaining a home of their own require a similar positive attitude on the part of officers and committee members of the departments concerned. (Paragraphs 987–993.)

Education departments

139. Officers in the education services, and in particular education welfare officers, are in touch with a large proportion of the child population of school age in their area. Many have continuing opportunity to note the significance of a child's behaviour at school in relation to the home situation. There must always be close co-operation between these workers and social workers in the health and welfare services when there are symptoms which indicate disturbance in the stability of family life.

140. Social workers in health and welfare departments should be available to assist education departments in making educational plans for severely mentally or physically handicapped children by offering an assessment of the family situation. They can support the parents whether the child is at home or away, and during school holidays. In co-operation with the youth employment service they can offer help in the transition to adult life at school leaving age, assist in adjustment, or arrange occupational and social activities for those incapable of employment outside the home.

141. We are not convinced that the various services designed to cover this critical period are always well co-ordinated, or that it is always appreciated that mentally or physically handicapped young people may need individual help in adjustment and in reaching the decisions which have to be made. Case conferences at this time are useful and we should like to see them held whenever appropriate. Social workers in health or welfare departments should also be available to those children leaving schools for maladjusted children for whom the Committee on Maladjusted Children recommended a service of personal help.

142. The help of the education department should always be sought if sick or handicapped people wish to study or undertake further education, and also, when appropriate, for craft teaching. (Paragraphs 994–1000.)

The Ministry of Labour and National Service

143. Co-operation between social workers in the health and welfare services, the youth employment service and the disablement resettlement officers of the Ministry of Labour and National Service is essential in the after-care of the handicapped and the sick, and also when unemployment is an element in family problems. The absence of supporting social work services in health and welfare departments may on occasions hinder the work of some of these officers, or lead them to attempt work which should be undertaken elsewhere. Certain groups of handicapped people may have special difficulty in obtaining and keeping employment, namely paraplegics, spastics, epileptics, the mentally disordered, those with progressive diseases, the tuberculous and the blind (for whom a special placement service is provided). As the community care, after-care, and welfare services for the handicapped become better developed, social workers in these services should increasingly be available to co-operate with disablement resettlement officers and to offer a casework service when required.
(Paragraphs 1001–1007.)

The probation service

144. In liaison with the probation service there will often be similar considerations to those outlined when the children's department is concerned. There should be similar agreement on the part to be played by each worker in adult and family problems. (Paragraph 1008.)

The welfare service of the Ministry of Pensions and National Insurance

145. Disabled war pensioners are eligible for registration as handicapped persons under the National Assistance Act. It is desirable that welfare officers in both local and central government services should work together, in order to ensure that disabled ex-service men and women are aware of the local authority services and are encouraged to use them appropriately.
(Paragraphs 1009–1010.)

146. Good co-operation exists in many areas between officers of the National Assistance Board and social workers in health and welfare departments (especially in the services for the blind). It is particularly desirable in the care of the elderly, with a proportion of unmarried and unsupported mothers, with some sick and handicapped people in receipt of national assistance, and with certain families who are receiving rent allowances from the Board and are in arrears with their rent. Co-operation between officers of housing, health or welfare departments and the National Assistance Board should be close whenever there is risk of eviction or family disruption for this reason.

147. Officers of the National Assistance Board meet many difficult situations where a trained social worker could be of assistance. The absence of supporting social work services in health and welfare departments must on occasions limit the help which can be given. Social workers in health (including mental health) or welfare services could assist in helping a proportion of people without a settled way of life who make use of reception or other centres provided by the Board, especially if they have been discharged from mental hospitals, or appear mentally unstable. They could also share in keeping in touch with those withdrawn people, mainly elderly, who discourage callers, some of whom may, if help is not given in good time, eventually reach the stage when compulsory removal to hospital or residential care becomes necessary. (Paragraphs 1010–1017.)

Making the services known : information and publicity

148. Good information services are essential in modern conditions and should be an integral part of the whole range of social services provided by local authorities. Services which meet individual and family needs must be known to those requiring them and to the general public, as well as to workers in related fields. Insufficient attention is sometimes paid to making services known locally, and to identifying people in need of help. A well planned information service should include publicity material suitably designed for the purpose, a central information bureau (which might be a public inquiry desk or citizens' advice bureau), local points of inquiry (wherever possible) and field workers well known in their districts. Both central and local arrangements are required. Officers receiving public inquiries should be experienced in such work, and have a good knowledge of the appropriate resources to which inquirers can be referred.

149. Many people find difficulty in distinguishing between services provided as a duty and under permissive powers. It is desirable that the position regarding the services available in any given area should be understood locally. Publicity material giving general information on the services should be designed from the consumer's point of view. Information bulletins for workers in related fields, on the lines of those issued by some authorities to general practitioners, are needed and would help to promote co-operation and facilitate contacts between field workers. Where an authority is prepared to offer a casework service this might be made known to general practitioners and other interested persons by this means.

(Paragraphs 1019–1026.)

Identifying people in need of help

150. It is equally important to identify those who need a service but do not know where or how to apply for it. Local publicity arrangements help to focus attention on the purpose of the services. Individual citizens need to know what to do if they come up against an obvious need or see that something is wrong. When an offer of help is unwelcome but action is required for the protection of the individual or others, then good neighbourliness shades into community responsibility and there should be a generally recognised way in each locality by which those responsible can be told that action may be needed. (Paragraphs 1027–1028.)

Prevention

151. Interpreting the danger signals before irreparable harm is done requires an effective visiting and reporting service. Where there is insufficient justification for intervention the information must not be overlooked or its significance missed. There should be a recognised procedure for this; the situation should be evaluated over a period of time, and the most promising method of approach assessed. This is real preventive work. We do not think departmental boundaries should be an overriding consideration in these matters as the arrangements must be sufficiently flexible to meet varying situations. The criterion should always be whichever working partnership is most suitable in the circumstances. (Paragraphs 1029–1030.)

The contribution of voluntary organisations and voluntary workers

152. The services within the terms of reference owe their origin to voluntary effort, often religious in inspiration. Such effort is still an active and integral part of the health and welfare services and is needed now and in future to supplement statutory provision, and to undertake work beyond the scope of legislation. Many important new voluntary services have come into being in recent years. The health and welfare services offer particular scope for new developments.

153. The traditional pattern of co-operation between statutory and voluntary organisations is changing because of the direct responsibilities of local authorities to provide social services, and the consequent employment of trained social workers. There is a tendency for local authorities to take over some services previously provided by voluntary organisations on an agency basis. (Paragraphs 1031–1038.)

Functions of voluntary organisations

154. The functions of voluntary organisations are to experiment, to initiate, to pass on responsibility to authority at a certain point if and when this is appropriate. This passing on is sometimes a necessary condition if experiment and initiative are to continue. Unless a voluntary organisation is relieved of established work it may not have the creative energy to undertake fresh pioneering. A further function is to assist the citizen in need of help in connection with a statutory service, and to keep the latter up to the mark. We agree with the Committee on the Rehabilitation, Training and Resettlement of Disabled Persons that the future of the voluntary services lies in the exploration and development of new fields of work, and in supplying personal interest and care. (Paragraphs 1039–1043.)

Relationships between local authorities and voluntary organisations

155. Voluntary organisations provide certain statutory services, often by agency agreement. There should be a clear understanding between both parties of the principles involved in these agreements. Apart from their statutory responsibilities, local authorities entering into agency agreements have an obligation to ensure by inspection, or other means, that the needs of those using the services are met, and that the quality of service given is satisfactory.

156. Some national, regional and local voluntary organisations which provide statutory services also provide certain other services for which local authorities may have no statutory responsibility but which are vital to a complete service. Liaison locally is facilitated by local authority representation on voluntary committees, and is fostered by good working relationships between local authority officers and voluntary organisation staff. Local authority officers should be readily available to officials of voluntary organisations. There are advantages in occasional meetings of statutory and voluntary field workers.

157. Authorities contributing to the funds of voluntary organisations can encourage specific developments, such as staff training, which have little public appeal and may thus be specially appropriate for local authority support. Where a substantial grant is given the authority has a continuing responsibility to ensure that a worthy service is rendered to the public. Social workers employed by voluntary organisations should be eligible for the general training in social work. This would promote interchange between the services and help to improve standards generally.

(Paragraphs 1044–1051.)

Functions of voluntary workers

158. Voluntary workers already play a large part in supplementing the statutory services. Some evidence suggested they might be directly recruited by local authorities to fulfil a 'general purpose social worker' function. We do not consider that this would either alleviate the manpower shortage in the local authority or enable voluntary workers to make their best contribution.

159. The functions of voluntary workers are distinct from those of local authority officers. They can provide a service for which there is no statutory responsibility and devote time to personal work with a few people. There is scope for the extended use of voluntary help under the guidance of trained social workers. Voluntary workers should be, and should feel themselves to be, an essential part of the team in the service with which they are concerned. Regular reports, to which attention is paid, should be asked of them.

160. Selection and training of voluntary workers is essential if they are to give their services knowledgeably and acceptably, and in order that they may recognise when a more highly trained worker is required.

(Paragraphs 1052–1059.)

Co-operation : co-ordination and team-work

161. There are three main aspects of co-operation, co-ordination and team-work, namely, planning the administration of local authority departments so that there is good co-ordination of effort within departments, between departments and between them and outside agencies: understanding among field

workers of each other's functions, and direct contacts between them; and agreement on the functions of co-ordinating committees and case conferences where such arrangements are in use. (Paragraphs 1063–1067.)

Co-ordinating committees and case conferences

162. Ninety-three per cent of authorities have co-ordinating machinery of one kind or another, while 50 per cent hold case conferences. These arrangements are mainly used in relation to the care of children, but there has been some development with family problems in general, with the elderly, and in particular in the welfare services for handicapped persons. Sixty-four per cent of authorities expressed themselves reasonably satisfied with these arrangements, 18 per cent were moderately satisfied and 18 per cent held no decisive opinion. No uniform pattern of designated officer, co-ordinating arrangement, or type of field worker, is distinguished in the first group. (Paragraphs 1068–1074.)

163. The varying views expressed in evidence on co-ordinating committees and case conferences suggests that a systematic study is required of the use of these arrangements in local government and in relation to the needs of those using the services. Research is required here as elsewhere we **recommend** that this should be undertaken. (Paragraph 1080.)

164. The distinction between the two methods of co-operation is not always clearly understood. The function of a co-ordinating committee is to work out and operate a plan for co-ordination in general terms, and to consider general questions of principle or policy. Committees of this type might only have to meet once or twice a year. They should consider individual cases only when these illustrate a point of policy, and then only in so far as discussion centres on the principle and not on the case as such. Membership should be representative of the type and needs of the area. The chairman should have a substantial grasp of the questions involved and ensure that the functions of the committee are clearly understood.
(Paragraphs 1081–1085.)

165. A case conference provides a setting for a limited number of workers directly involved in the case under consideration to assess the need, work out a plan of concerted action, and carry it out in co-operation with each other and with the person or family involved. Case conferences are mainly used in situations where children are neglected or ill-treated in their own homes, or in work with 'problem' families. They could be used with advantage in all work with families, including unmarried and unsupported mothers, in the mental health service, with elderly people and the care of the physically handicapped. Case conferences should only be attended by officers actively involved in the case under discussion, one of whom should take the chair. It is not in our view appropriate for members of statutory or voluntary committees as such to attend. (Paragraphs 1086–1089.)

166. Confidence should be strictly preserved at both co-ordinating committees and case conferences. This is fundamental to professional relationships but does not always seem to be clearly appreciated. We **recommend** that authorities who have not already done so should review their arrangements, including those for presenting information in committee papers, and consider how confidentiality can be effectively preserved. (Paragraph 1090.)

Co-operation and referral between workers

167. Regular meetings of field workers in a compact locality are valuable in promoting understanding of each other's functions. Recognition of the point at which another worker or service should be consulted is essential in social work, but co-operation and referral will follow only from common understanding and common purpose. It is also facilitated by a common training and, sometimes, by arrangements for shared services.

168. Administrators and field workers must keep each other informed if problems are to reach the appropriate service, or a case conference, in time. Elaborate reporting is not necessary but there should be two-way communication. Contacts with related services may be arranged centrally or at field level according to the best administrative practice in the circumstances: normally direct contact between field workers is the quickest and most effective method. (Paragraphs 1091–1096.)

Multiplicity of visiting: team-work

169. Much of the evidence suggested that current accounts of multiplicity of visiting and overlapping of effort are exaggerated. There is some evidence that where multiple visiting exists it is related to the number of children in the family and their age distribution. The real problem is not so much multiple visiting, as multiplicity of independent and unco-ordinated visiting. There is a distinction between multiple visiting, and overlapping of visiting which may lead to the giving of conflicting advice. In some situations more than one worker may ultimately be required, but only one should undertake to gather any additional material on which the initial assessment is based.

170. Co-ordination of visiting is one aspect of team-work. People do not normally feel part of a team unless they appreciate the effect of the combined operation, and the working method and function of each member. The elements in good team-work are, therefore, an administrative structure which facilitates co-operation, good working relationships between different types of officer and departments, and opportunities for regular meetings and discussion at all levels. (Paragraphs 1097–1102.)

PART I

Chapter 1

THE SERVICES WITHIN THE TERMS OF REFERENCE:

HISTORICAL AND GENERAL

171. Our terms of reference were "to enquire into the proper field of work, and the recruitment and training of social workers at all levels in the local authorities' health and welfare services under the National Health Service and National Assistance Acts . . .". Our first task therefore was to determine those services within the framework of the Acts which fell within this remit. We were guided in this by the functions of the staff already employed, the needs of those for whom the services are provided, and the application of social work to these needs.

172. Under the National Health Service Acts local authorities provide some services for specific medical and health purposes; others in addition also meet certain social needs. Viewed in this way, the health services with which we are concerned are, broadly, health centres, some aspects of the arrangements for the care of mothers and young children (in particular, unmarried mothers), the prevention, care and after-care services, both generally and in combination with services under the Lunacy and Mental Treatment and Mental Deficiency Acts, and the domestic help service, more usually called the home help service. The extent of our interest in relation to each service is further defined below. The services which lay outside our province were midwifery, health visiting, home nursing, vaccination and immunisation and the ambulance service. Under the National Assistance Act we were concerned with all the main local authority services, that is residential and temporary accommodation, some welfare provision for the elderly, and the welfare services for the handicapped, namely the blind and partially sighted, the deaf and hard-of-hearing and the general classes of handicapped persons.

173. In this and the following chapters we shall trace the history and development of these services, mainly from the social work point of view, and review the present position, commenting on it in the light of our individual experience and of the knowledge acquired in the course of our inquiry. Services which meet human needs cannot be considered apart from the officers who staff them since the personal qualities and qualifications of these officers sometimes constitute the service itself. We shall indicate the type of staff at present employed, their functions, and the social work content of their work, and then go on to consider the needs of those using the services, the types of social worker which seem to us to be required, and the recruitment and training of such staff generally.

174. An historical analysis of the growth of the health and welfare services as they concern us shows that these, like other social services, came into existence in different forms at different times because some individual

enthusiast or group of pioneers became deeply conscious of a need and tried to meet it, or else because social reformers struggled to arouse their fellow citizens to awareness of the hardships suffered by the more unfortunate of their number.

175. In the course of our inquiry it has been brought home to us that in many aspects these services still represent separate strands of history, only recently interwoven, and each preserving much of the particular motive power which brought it into existence. We cannot in a short space consider in detail the social, philanthropic, political and economic elements in largely unrelated patterns. Two may be briefly mentioned, namely certain aspects of the corresponding and roughly parallel development of local and central government, and the influence of the Poor Law. Between the latter half of the nineteenth century and the early part of the twentieth the number and variety of authorities, each with different powers and responsibilities, slowly gave place to a consolidated administration. The Local Government Acts of 1888/1889 and 1929 established the present structure of local government, and gradually concentrated in two types of authorities (councils of counties and county boroughs in England and Wales, councils of counties and large burghs in Scotland) the powers and duties relevant to many of the services with which we are concerned. In central government the Ministry of Health, with greatly expanded functions, took over from the Local Government Board in 1919 and the Scottish Board of Health (which became the Department of Health for Scotland in 1929) was established in the same year. The Board of Control in England and Wales, and the General Board of Control in Scotland, were established in 1913 with functions previously exercised by the Commissioners in Lunacy and the General Board of Commissioners in Lunacy respectively.

176. During these years voluntary effort was engaged in promoting a range of services outside the Poor Law, including general and special hospitals, the care of homeless and destitute children, and of the physically and mentally ill and handicapped. The desire to establish new types of care was a potent factor in the early development of many of the services within our terms of reference. The Poor Law has sometimes been described as the first statutory social service in this country, and for many years it represented the only organised attempt by the State to meet the sicknesses of body and of mind, and the economic and other misfortunes and disasters which befall human beings. It was not sufficiently flexible, however, to meet rapidly changing conditions and by the end of the nineteenth century was far out of accord with the spirit of the times. The ' break-up of the Poor Law ' was a lengthy and hotly debated process. It might be said to have received official blessing in the Local Government Acts, 1929, which enabled local authorities to provide certain services for which there was provision in the Poor Law " otherwise than by way of poor relief ".

177. The legislation of 1929 and 1930 went some way to meet the recommendations of the Royal Commission on the English Poor Laws, 1905–1909. This famous Commission, which issued Majority and Minority Reports, made certain unanimous recommendations including the abolition of the boards of guardians and the enlargement of administrative areas from the Poor Law unions to counties and county boroughs. The Majority Report recommended a new statutory and voluntary framework to include also the establishment

of a public assistance service with a qualifying examination for senior officers, and appropriate salary scales. The Minority Report drew a distinction between those who were able-bodied and those who were not, recommending that responsibility for the latter should be divided between existing committees of county and county borough councils, and that the former should become the concern of a new authority, the Ministry of Labour.

178. There was no immediate legislative result from the two reports and in 1917 the Local Government Committee (the Maclean Committee) went over some of the ground again. Like others before it, the Committee recommended[1] the abolition of the boards of guardians and Poor Law unions, and the transfer of their functions partly to existing committees of county and county borough councils, and partly to new committees to be called the prevention of unemployment and training committee and the home assistance committee, the latter to be responsible for all grant aid in money or in kind. In putting the case for a home assistance committee, the Maclean Committee drew attention to the number of different authorities giving financial, institutional and medical assistance in various forms :—" These public bodies, many of them extending over different areas, have with a few exceptions no common system of registration of cases so that even the names of persons receiving assistance from one or more of the bodies may be unknown to some other body which may be considering their case. This absence of common knowledge results in much overlapping, and also in occasional failure to detect cases of need ". This sentence has a familiar modern ring.

179. By the mid 1930's the boards of guardians in England and Wales were finally abolished and their functions transferred, as had been so long and unanimously recommended, to county and county borough councils. In England and Wales the Poor Law Examinations Board, set up in 1910, was reconstituted in 1932. In Scotland a similar Board had been established in 1909. Many public assistance officers now took the examinations, which received some recognition although they did not become a pre- or post-entry requisite to appointment, as the Majority Report had planned.

180. With the transfer of functions, local authorities inherited heavy responsibilities for meeting human needs, and in addition the task of modernising the public assistance service in as far as this could be done within the existing statutory framework. In some areas little had been achieved before the outbreak of war in 1939 but in others progressive authorities and their officers administered the service in as flexible a manner as the legislation permitted. Between the end of the war and 1948 further efforts were made to improve institutional care, particularly of children. In the course of our visits we have met some of the officers who played a part in the final era of the Poor Law. Many have welcomed the greater flexibility and new attitudes of the present service and thus enriched it with their wide experience and humanity.

181. The concern of central and local government with public health is essentially a development of the last hundred years. It was an appropriate and nice coincidence that the National Health Service Act " appointed day " on 5th July, 1948, should have fallen in the centenary year of the first Public Health Act in 1848, and, broadly speaking, also of the appointment (by

[1] Cd. 8917. 1917–18.

private Acts of Parliament) of the first medical officers of health, in Liverpool in 1847, and in London in 1848. The history of public health legislation affecting all three countries shows a gradually widening concept, as knowledge grew and attitudes changed, of what is involved in promoting the health of the community. The first concern of the sanitary reformers of the nineteenth century was, broadly, to provide for basic health needs and to control disease, principally cholera, the enteric fevers, typhus and smallpox, by improvement in environmental conditions—a pure water supply, adequate sewers, hygienic disposal of waste, improved housing, and the paving and cleansing of streets in the sprawling urban areas created by the industrial revolution. They turned next to the compulsory notification of certain infectious diseases and the provision or extension of facilities for isolation and medical treatment. The Public Health Acts, 1875 and 1897, consolidated and established the environmental services, and after the turn of the century public health legislation gradually moved towards the provision of preventive services for individuals as a means to achieving a healthy community. The present century has seen the growth of the personal health services and the recognition of social medicine. These changes have been a necessary, although often unrecognised, corollary of the immense developments in scientific medicine and bio-chemistry.

182. During the past fifty years, there has been a growing appreciation of the importance of social and emotional factors in the causation and progress of disease. The nineteenth century mechanistic concept in which every disease process had a cellular pathology due to some definite causal factor has gradually been superseded by the broader concept of disease as a reaction of the individual to some causal factor. This may be an infecting agent, injury, abnormal new growth, or degeneration within the body tissues, or a social factor. Most frequently there is more than one underlying cause producing the illness. In the past the importance of social factors in disease was in the main neglected. They are in any event more difficult and time-consuming to assess and treat. In spite of the great scientific advances in medicine, which have produced powerful new curative drugs and other successful treatments, medical men are coming to appreciate the importance of treating the 'whole man' in his social environment rather than simply treating a disease process. The importance of assessing and treating the social factors in disease has only recently begun to be recognised. It is not surprising that most progress has been made in the field of psychiatry, and the psychiatric social worker is now generally recognised as essential to the medical team dealing with mental disturbance. Similarly, work has been done with certain other diseases which present social problems such as tuberculosis, the venereal diseases and diabetes. But a great mass of human suffering still remains to be tackled—the minor illnesses which fill the general practitioners' surgeries and cause much industrial absenteeism, together with the 'stress diseases' which include, among many other common complaints, conditions such as anxiety states, effort syndrome, insomnia, vascular headache and certain skin diseases.

183. The first public health services were linked administratively with the Poor Law, and developed separately from the early mental health services. The Local Government Acts, 1929, vested local responsibility for both services in the one authority, though not as yet in the same committee. There was no obvious connection in the early days between public health,

concerned mainly with sanitation and infectious disease, and the care of those suffering from mental illness or defect; indeed, medical opinion favoured separate administration of the latter in order to concentrate on the complexities of mental illness, and on new forms of medical treatment. Although both groups were engaged in pioneer work and were at one in a desire to be dissociated from the Poor Law, each was concerned only with developments in its own sphere, and thus helped to contribute to the common tendency to think in separate terms of the mentally and physically ill and handicapped. One of the many notable changes introduced by the National Health Service Acts was the specific inclusion of mental health within the general framework of the service.

184. The 1930's were characterised by administrative reorganisation following the Local Government Acts, 1929, and consolidating legislation in a number of fields covered by our inquiry, but the pattern was still incomplete at the onset of the second world war. There were few trained social workers in local authority services before 1939. Possibly the earliest to be employed as such were the London County Council Care Committee organisers in the school care organisation set up early in the present century to implement the Education (Provision of Meals) Act, 1906. Later a few workers with a social science certificate or diploma were recruited to education, housing or public assistance departments. After 1929 almoners were appointed to some municipal hospitals, sanatoria and tuberculosis dispensaries, but psychiatric social workers were still mainly to be found in voluntary hospitals and clinics even as late as 1939.

185. The part played by social workers in the war-time local authority services and the encouragement given by the Ministry of Health and the Department of Health for Scotland to such appointments to assist with the problems of evacuation, billeting and homelessness, and later with those caused by the rising incidence of illegitimacy, tuberculosis and venereal disease helped to bring about a more general recognition of the place of social work in local government. Some of the experienced social workers in the evacuation services eventually joined the staffs of children's departments in 1948, and the use of such workers in the child care service is now generally accepted. In the older established public health services, and in the welfare services created by the National Assistance Act, a similar recognition has been slower, partly because there was not the same urgency to create a new department and a new service, and partly because officers were already available to whom new duties could be given.

SERVICES PROVIDED UNDER THE NATIONAL HEALTH SERVICE ACT, 1946, AND THE NATIONAL HEALTH SERVICE (SCOTLAND) ACT, 1947

186. The National Health Service Acts transferred both local authority and voluntary hospital and specialist services to the Minister of Health and the Secretary of State for Scotland, and consolidated the domiciliary health services in the local health authority.[1] The powers and duties of these authorities which meet social as well as medical and health needs and are thus within our terms of reference are:

(1) The provision of health centres with facilities for general medical, dental and pharmaceutical services, any service which the local

[1] Councils of counties and county boroughs in England and Wales, councils of counties and large burghs in Scotland.

health authority is required or empowered to provide, and specialist or other services for hospital out-patients. (Section 21 in England and Wales: the Scottish Act places this duty on the Secretary of State.)

(2) The care of expectant and nursing mothers and of children under 5 years of age who are not attending school. (Section 22 in both Acts.)

(3) The prevention of illness and the care and after-care of persons suffering from illness (including mental illness) or mental defectiveness. (Section 28 in England and Wales; Section 27 in Scotland.) In respect of mental illness and mental deficiency these powers are complementary to the powers and duties imposed by the Lunacy and Mental Treatment and Mental Deficiency Acts.

(4) The provision of domestic help for households where such help is required owing to the presence of a person who is ill, lying-in, an expectant mother, mentally defective, aged or a child not over compulsory school age. (Section 29 in England and Wales; Section 28 in Scotland.)

The powers provided by Sections 28 and 29 in England and Wales and Sections 27 and 28 in Scotland are permissive except for such as are made a duty; at present these include only arrangements for the prevention of tuberculosis and the care and after-care of persons suffering from that disease. Services under the National Health Service Acts are under the direction of the medical officer of health who is responsible both to the council and for the day-to-day administration of the services.

HEALTH CENTRES

187. The provision of health centres is still in the experimental stage, although the idea is not new and was much discussed during the 1920's. As envisaged in the National Health Service Acts, health centres provide facilities for general practitioners and for dental and pharmaceutical services, for any of the local health authority's own services, and for specialist or other hospital out-patient arrangements. In 1948 a Committee appointed by the Central Health Services Council considered the general lines along which health centres might be developed in England and Wales. Two recommendations in the Committee's report touched on our inquiry, namely that where convenient the domestic help service might be organised from the health centre, and that a 'socio-medical' worker should be appointed by the local health authority to help general practitioners with these aspects of their work. In addition to providing a casework service such workers might also be engaged in the local authority's own care and after-care services, and in assisting persons who required help from other statutory or voluntary sources.

188. A small number of health centres have been built since 1948, mainly on new housing estates or in new towns. In two of these an almoner, and in one a psychiatric social worker, has been appointed or attends certain sessions either to assist patients with social problems, or to give short talks to certain groups. There has also been some development of the group practices envisaged in the Acts. An indication of the social needs arising in both these settings is given in paragraphs 414 to 418.

189. The care of mothers and young children is fundamental to local authority services for families. Some aspects were therefore relevant to our inquiry, and in particular the care of unmarried mothers and the social problems of illegitimacy, both well established fields of social work.

190. The maternity and child welfare services have their roots in the late eighteenth and early nineteenth centuries when a high infant and child mortality rate, the abandoning of children, child labour, and the 'pauper apprentice' were among the accepted conditions of the day. By the first world war much progress had been made in improving standards of midwifery and child care and in providing school meals and other health services. War-time conditions accentuated the need for further provision, and maternity and child welfare legislation at this time resulted from current anxieties about existing deficiencies and about the birth and infant mortality rates after a long and devastating war. In England and Wales the Maternity and Child Welfare Act, 1918, indicated the changing social conditions which made it desirable to promote (under this Act) a home help service[1] for some expectant mothers unable to obtain help in the home during confinement, and also recognised the special problems of mothers with illegitimate children. The Local Government Board,[2] in outlining the provisions of the new Act to maternity and child welfare authorities, drew attention to the high death rate amongst such children (at that time about double that of children born in wedlock) noting that this was partly due to the difficulties such mothers found in making a home for their children.

191. This official recognition of the problems of unmarried mothers coincided with the founding, in the same year, of the National Council for the Unmarried Mother and her Child and marked a new approach to an old problem hitherto largely ignored. The social distress of mothers and young children which inspired the pioneers of the maternity and child welfare services was far exceeded by that of the unmarried mother and her child at that time. The weight of public censure and the practical and economic difficulties caused many to abandon their children as the only alternative to the poor law institution which in itself offered no constructive solution. Mothers admitted before confinement, or after with their infants, often spent the remainder of their lives in institutional care. Voluntary help towards the end of the nineteenth century often took the form of separating mother and child, and sometimes provided for the mother only if she was prepared to accept social and moral condemnation as the price of practical help.

192. Gradually the need for a more constructive approach was realised. The early 'penitentiaries' were replaced by 'shelters', and the value of 'rescue' work as a means of providing practical help became more generally recognised. Much of this change in social climate was due to the work of a few courageous and far-sighted people; principally Josephine Butler, who in the face of apathy and active opposition challenged the injustice meted out to the unmarried mother, and Dr. Barnado, whose scheme of assisting such mothers financially to enable them to board out their children is still operative.

[1] See paragraph 240.
[2] Local Government Board Circular, 9th August, 1918, paragraph 33.

193. Voluntary services for unmarried mothers and their children are mainly provided by religious organisations including the Salvation Army. In the Anglican and Roman Catholic Churches this work is known as moral welfare. It includes general sex education and education for marriage based on Christian principles, work with unmarried mothers and women and girls in moral danger, and residential care in homes, hostels, shelters and training homes. Training for moral welfare workers is provided on a non-denominational basis at Josephine Butler Memorial House in Liverpool, and may include the social science certificate course at Liverpool University. There is also a six months' course held annually in London organised by the Church of England Moral Welfare Council for older women with good relevant experience. The National Council for the Unmarried Mother and her Child acts as an advisory and co-ordinating body, and has also pressed for reform or amendment of legal measures affecting unmarried mothers and their children. The Scottish Council for the Unmarried Mother was founded in 1945 to secure the co-operation of all organisations concerned with the welfare of these mothers and their children.

194. Although central government departments drew attention to the problems of illegitimacy as long ago as 1918, direct local authority services have developed slowly and it is only comparatively recently that local authority officers have undertaken such work. This was partly because of the generally accepted idea that unmarried mothers were properly the concern of religious or voluntary bodies, and partly because those who came the way of the statutory authorities were usually provided for under the Poor Law, which also made separate provision for the children.

195. The second world war led to a fresh rise in the incidence of illegitimate births, and also to immense difficulties in providing the normal maternity services adequately under war-time conditions. The problems of unmarried mothers were greatly increased, especially in obtaining vacancies in residential or day nurseries or finding other means of caring for young children. In 1943 the Ministry of Health drew attention to the importance of arranging for the care of illegitimate children and suggested that authorities should formulate schemes for this purpose in association with the voluntary organisations and moral welfare associations. It was recognised that the range of need would be wide, and the appointment of trained workers experienced in the special problems involved would probably be an essential part of the scheme. These workers " should have taken one of the recognised courses of training in social service and also have some knowledge of moral welfare ; experience in probation work would be valuable ".[1] Some authorities might wish to use a social worker already on their staff engaged in the evacuation services, or one whose appointment had followed an earlier circular on the social problems arising from venereal disease.

196. In response to this circular, most maternity and child welfare authorities in England and Wales submitted schemes specifying co-operation with a local moral welfare association. Fifty authorities appointed special workers, and some arranged for a health visitor to gain experience with a local voluntary association. These arrangements continued until, under the National Health Service Acts, local authorities were required to make provision for the care of unmarried mothers as part of their maternity and

[1] Ministry of Health Circular 2866, paragraph 4.

child welfare services. Generally speaking they have continued their partnership with voluntary associations and there is less tendency to take over direct responsibility for this service than for some others with which we are concerned. A few authorities provide care under the National Assistance Act (to which further reference is made in paragraph 498), either by *per capita* payments to voluntary organisations or directly in residential or temporary accommodation, though mainly in the latter, since there is a general desire to avoid the sharing of accommodation with elderly, infirm or handicapped persons. Admission to temporary accommodation may, however, provide the opportunity of giving constructive help to a group of mothers (some of whom may have more than one child) who are unresponsive to help from a voluntary organisation.

197. In this brief résumé of the care of unmarried mothers, we have noted that the first efforts to help had the effect of separating mother and child. Gradually the emphasis has changed to keeping them together wherever possible, though this approach sometimes stops short of considering the changing situation as the child grows up. In recent years there has been much more concern about this and other problems of illegitimacy. There is also a new interest in 'unmarried fathers', in our view a most neglected group. The Church of England Moral Welfare Council and the National Council for the Unmarried Mother have promoted or are themselves undertaking research into various aspects of illegitimacy. In London and Bristol the local authorities have initiated long term research projects which should provide valuable information. A follow-up study in 1954–55[1] of 284 illegitimate children born in Leicester in 1949 showed that some 70 per cent of mothers were either married or cohabiting (65 per cent keeping their children, but about 5 per cent with children living with relatives). Of the remainder half (15 per cent) had parted with the child (usually by adoption), and half (again 15 per cent) had kept the child (9–10 per cent with previous children, 5–6 per cent as an only child). About 1 per cent had had subsequent illegitimate children. In about 30–40 instances no information was available about mother or child.

198. The number of registered illegitimate births has remained fairly constant in England and Wales at around 32,000 a year over the past 6 years, or 4·7 to 4·8 per cent of total registered births and in Scotland at 4,100 (4·3 per cent to 4·8 per cent). It is not possible to estimate how many of these children or their mothers, before or after confinement, might require care and help from the health and welfare services though the proportion is likely to be high. A tentative guess could perhaps be made by applying to the total number the percentages determined by Dr. Macdonald in Leicester. On this basis the need is most likely to arise where the child remains with the mother who is neither married nor cohabiting (estimated at about 5,500), or where the child is living apart from his mother with relatives (estimated to number about 1,700). Figures provided by the Home Office show that in the year ended 31st March, 1957, 1,142 illegitimate children came into the care of local authority children's departments in England and Wales because their mothers were unable to provide for them; no figures are however available for the number of illegitimate children coming into care for other reasons, nor for those accepted by voluntary organisations.

[1] "The follow up of Illegitimate Children" by Dr. E. K. Macdonald, M.D., O.B.E., D.P.H. (1956), *The Medical Officer*, Vol. XCVI, No. 24, pp. 361–365.

The number of illegitimate children adopted under orders made in 1956 was 10,457 in England and Wales (of whom 6,617 were adopted by persons unrelated to them) and 1,151 in Scotland. Present arrangements for care under the National Health Service and the National Assistance Acts are described in paragraphs 419 to 425 ; staffing is referred to in paragraph 345.

PREVENTION, CARE AND AFTER-CARE

199. The powers under Section 28 (Section 27 in Scotland) of the National Health Service Acts gave local authorities wide scope to develop a range of preventive and after-care services. This scope has been limited to some extent by national restrictions on expenditure, but there have been a number of interesting developments in social work in recent years. At the outset it was expected that apart from providing for the after-care of the tuberculous and those suffering from venereal disease or mental disorder, these services would mainly be required for persons discharged from hospital, for the loan of nursing or other equipment for the sick at home, and in arranging for convalescence not provided as part of hospital treatment. Local health authorities were asked, however, to show in their proposals details of any other arrangements it was desired to make, including the employment of social workers.

200. Soon after 1948 some authorities employing almoners in the tuberculosis and venereal disease services widened the functions of these officers to include more general work with, for example, the social care of patients discharged from hospital. Others arranged for the almoner's services to be available to general practitioners to assist with social problems arising from illness in the home. In one or two areas, by agreement with the hospital management committee, the health department almoner had access to hospitals or sanatoria, where no almoner was employed, in order to provide continuity of social care.

201. Local health authorities have also used their powers under these Sections to assist families in difficulties of various kinds, and in particular if there is neglect of children or risk of family breakdown. Some have sent mothers in ill health and overburdened with family cares, or neglectful of their children, to the recuperative centres provided by voluntary organisations, such as Brentwood in Cheshire, Spofforth Hall near Harrogate[1], or St. Mary's Mothercraft Training Centre at Dundee. Others have contributed to or promoted the setting up of Family Service Units in their area. During the war and since, the pioneer work of these Units has helped to focus attention on those families whose standards of home life and child care are seriously below normal—the so-called ' problem ' families known to all workers in the social services. Various attempts have been made to define ' problem ' families: we use the term for convenience throughout this Report, though we agree with the evidence of the Family Service Units that they are not a homogeneous group.

202. A number of authorities contribute to the funds of the National Society for the Prevention of Cruelty to Children or the Royal Scottish Society for the Prevention of Cruelty to Children, or make grants towards the salary

[1] This centre moved during 1958 to Elizabeth Fry Home, Acomb, York.

of a local worker. In 1950 public concern about child neglect or ill treatment led to the issue of circulars[1] on preventive measures by the Scottish Home Department and, jointly, by the Home Office, Ministry of Health, and the Ministry of Education. These recommended co-ordinating arrangements to make the most effective use of existing resources, and the designation of an officer to secure co-operation between the statutory and voluntary services concerned with the welfare of children. These suggestions, which are discussed further in Chapter 12, were adopted by the majority of authorities and are now widely applied in considering a range of family and other social problems.

203. In 1954 the Minister of Health and the Secretary of State for Scotland[2] again drew the attention of local health authorities to the ill effects on the health, particularly the mental health, of children, which followed the break-up of family life, and to the importance of their domiciliary services in helping to keep families together. Authorities which did not already use the care and after-care or the home help services in this way were asked to consider whether more could be done, and also whether better use could be made of existing staff, for example, health visitors and mental welfare officers, or of workers from voluntary organisations accustomed to dealing with family welfare or 'problem' families. It was recognised that some authorities would wish to employ a trained caseworker who might be one engaged in similar work under other powers. Whatever the arrangements, the particular needs of each family should be studied and met in appropriate ways. Some examples of these varied developments are given in paragraphs 442 to 444.

Tuberculosis : the Growth of Social Care

204. Local health authorities have a duty to provide tuberculosis services, continuing the previous duty under the Public Health Acts dealing with that disease. Tuberculosis has been a notifiable disease only since 1912, but the social implications have long been recognised. It is stimulated by overcrowding, bad housing, malnutrition and squalor, and the effects can be disastrous in terms of economic difficulty, lowered standards of living (with consequent lowered resistance to infection) and disruption of family life. Social care may be said to have developed concurrently with medical treatment, with education in adjustment to chronic illness and with measures to avoid the infection of others. Indeed the first tuberculosis dispensary, which was established in Edinburgh in 1887, was also notable for the first voluntary Samaritan Committee providing after-care. Care committees and after-care arrangements have since been part of many tuberculosis services in England and Wales, and from time to time the Local Government Board, and subsequently the Ministry of Health, reminded authorities of their value, suggesting that where they were lacking they should be promoted either directly, or through voluntary effort.

205. Before the first world war, sanatoria and tuberculosis dispensaries were provided by voluntary effort and by some sanitary authorities but did not cover the country as a whole. By 1939 there were over 450 dispensaries in England and Wales and some 90 local care committees affiliated to the National Association for the Prevention of Tuberculosis. In Scotland there

[1] Home Office Circular 157/50, Ministry of Health Circular 78/50, Ministry of Education Circular 225/50; Scottish Home Department Circular 7497.

[2] Ministry of Health Circular 27/54; Department of Health for Scotland Circular 73/1954.

was similar growth of provision generally, but the care committee system did not develop to the same extent and local authorities themselves provided extra nourishment, beds and bedding, and other help in kind. Voluntary effort also established the village settlements for the tuberculous which provide medical treatment, training, and rehabilitation and resettlement.

206. The increase in incidence during the second world war led to further measures to improve facilities for medical diagnosis and treatment, and also to the payment of allowances to encourage certain categories of those suffering from tuberculosis to undergo treatment. The function of the care committee, as outlined in a Ministry of Health circular,[1] was to provide ancillaries to medical treatment and to give financial or other practical help. The function of the almoner was to undertake medical social work with tuberculous patients and their families, to act as the link between the patient, the tuberculosis officer and the care committee, and to arrange, in co-operation with the disablement resettlement officer, for training or re-employment. After the war local authorities were asked, in drawing up their schemes under the National Health Service Acts, to consider how far existing care committees could provide an after-care service. It was suggested that these committees should co-operate with, but not overlap, the medical, health visiting and social services, and thus assist in solving the problems of tuberculous households and facilitate treatment by relieving anxiety and helping to prevent relapse.

207. In paragraph 184 we noted that some of the first almoners employed in local government service were appointed to the tuberculosis service, where the majority are still engaged. Training for almoner's work has been provided since 1905 by the training courses of the Institute of Almoners and, since 1954 and subsequently, by the medical social work course at Edinburgh University, and the courses in social casework and applied social studies at Birmingham and Southampton Universities and the London School of Economics. The training, qualifications and functions of almoners were considered in 1951 by one of the Committees on Medical Auxiliaries under the chairmanship of Mr. Zachary Cope. The Committee regarded the almoner as a social caseworker, primarily in the medical and hospital field, but they also recognised considerable scope for other activities. They did not feel it within their province to define the limit of almoners' functions beyond saying that almoners should be regarded as one of the essential elements in a complete health service. In the Committee's view the nature of the work made it desirable that training should include practical knowledge of the work of local health authorities.[2] The work of almoners in the local authority setting is considered further in paragraphs 432 to 434 where we also outline the present position in this service. Details of staffing are given in paragraphs 345 to 348.

208. Recently the Committee on the Rehabilitation, Training and Resettlement of Disabled Persons (the Piercy Committee) made recommendations regarding tuberculous hospital patients, and the need for hostels for those whose home circumstances were unfavourable, or for whom suitable employment could not be found near home. They also recommended that inquiries

[1] Ministry of Health Circular 2794; Memo. 266/T.
[2] Cmd. 8188 Part II, paragraphs 113–115 and 150.

should be made, on the basis of registrations at chest clinics, to ascertain how far there were appreciable numbers of the tuberculous remaining unemployed who might start work again if given the proper measures of rehabilitation, including social rehabilitation.

209. Although new methods of medical treatment have reduced the mortality rates from all forms of tuberculosis in recent years the numbers on the registers have not fallen. The total number of notified cases on chest clinic registers at 31st December, 1957, was 351,768 (176,640 men, 146,045 women and 29,083 children), and showed a slight increase over the figure of 351,212 cases (174,105 men, 145,559 women and 31,548 children) at 31st December, 1956. The equivalent figures in Scotland were 59,572 (27,653 men, 26,669 women and 5,250 children) and likewise showed a slight increase over the figure of 57,078 (25,649 men, 25,747 women and 5,682 children) a year earlier. The number of new cases in England and Wales declined from 35,504 in 1956 to 32,669 in 1957. In Scotland, however, the number of cases discovered increased from 5,682 to 6,650. This is attributed to the mass miniature radiography campaign, rather than to an increase in incidence.

Venereal Disease : the Social Aspects

210. Responsibility for the prevention and treatment of venereal disease was placed on local authorities only during the present century. Previously the control of prostitution was regarded as the main preventive measure and though the extreme steps in state regulation found elsewhere in Europe were never taken in this country the Contagious Diseases Acts, 1864–69, imposed a limited control for a time. These Acts, which provided for the compulsory medical examination of prostitutes, were repealed in 1886, following the abolition campaign led by Josephine Butler and others. There was no further statutory provision until the first world war. The Royal Commission on Venereal Diseases, which reported in 1916, recommended that treatment should be available free of charge, and local authorities were subsequently required by war-time regulations under the Public Health Acts to make such provision.

211. The lengthy period required at that time for medical treatment and observation added to the intense personal and family problems inherent in venereal disease. One obvious difficulty was lack of suitable accommodation for infectious women and girls whose home conditions were unsatisfactory. Often there was no alternative to admission to a Poor Law infirmary but some moral welfare and other voluntary associations set up hostels for women and girls under treatment including those who were also pregnant. These provided an opportunity to give constructive help, especially to those who might otherwise have drifted into prostitution, and of becoming familiar with the many social problems involved. Much less has been attempted in the way of social work with men suffering from venereal disease.

212. In this country diagnosis and treatment are available confidentially, but the diseases are not notifiable. Following the rise in incidence during the second world war and after, that is, between 1942 and 1947, limited powers of notification and compulsory medical treatment were provided by Defence Regulations. In 1943 the Ministry of Health and the Department of Health for Scotland suggested that authorities which had not already done so should consider the appointment of trained almoners to deal with the social

problems, and to help in building up the good relationship essential for regular clinic attendance and for follow up. Such work is still a function of some local health authority almoners, a few of whom also undertake contact tracing and the follow up of defaulters, though this is more usually regarded as health education and therefore appropriate to the health visitor. In some instances there is joint use of the services of almoners or other social workers by hospital clinic and local health authority. Information on the staffing of this service is given in paragraph 345 ; the present picture is described in paragraphs 436 to 438.

213. New methods of medical treatment and of reducing the spread of infection have completely altered the situation in recent years. Since 1939 the number of persons suffering from syphilis attending centres for the first time in England and Wales has dropped by about 60 per cent to an average, in 1957 and the first 6 months of 1958, of 1,134 per quarter. Diagnosis of congenital syphilis has become rare. The numbers with gonorrhoea attending clinics for the first time in 1957–58 have fluctuated between 5,073 and 7,155 per quarter, and there are some indications of a recent increase. The social consequences of these far reaching new methods of medical treatment are only gradually being revealed but the changing attitude, especially among young people, towards venereal disease may indicate a new aspect of a complex social problem.

The Mental Health Service

214. The history of the mental health and mental deficiency services in England and Wales has recently been reviewed by the Royal Commission on the Law relating to Mental Illness and Mental Deficiency[1]. Comparable reviews of Scottish services are contained in the Report of the Committee on the Scottish Lunacy and Mental Deficiency Laws[2] (the Russell Committee) published in 1946, and in 1955 in a White Paper[3] on the Law relating to Mental Illness and Mental Deficiency in Scotland. We do not propose to cover this ground again, but only to outline briefly the present powers and responsibilities of local authorities in England and Wales, and in Scotland, and to refer to terminology.

215. In England and Wales, the Lunacy and Mental Treatment Acts, 1890–1930, and the Mental Deficiency Acts, 1913–1938, authorised county and county borough councils to provide institutional and community care for the mentally ill and defective, and laid down the legal procedures and compulsory powers under which such care should be provided. In Scotland, the relevant legislation is the Lunacy (Scotland) Acts, 1857–1913, and the Mental Deficiency and Lunacy (Scotland) Acts, 1913 and 1940 ; the authorities concerned are the councils of counties and large burghs. The provision of occupation centres for trainable defectives is a duty of the education authority under the Education (Scotland) Act, 1946.

216. The Mental Treatment Act, 1930, made provision in England and Wales for the admission of the mentally ill to mental hospitals as voluntary or as temporary patients without certification, and also empowered local authorities to make provision for the after-care of persons suffering from mental illness, and to contribute to the funds of voluntary associations

[1] Cmnd. 169. [2] Cmd. 6834. [3] Cmd. 9623.

providing such care. Similar provision in relation to voluntary associations undertaking work with mental defectives not requiring institutional care was made in both countries by the Local Government Acts, 1929.

217. The Lunacy Acts applied to all types of mental illness and some forms of mental defect until 1913. In that year Mental Deficiency Acts in England and Wales and in Scotland made provision for mental defectives not considered certifiable under the Lunacy Acts. The term 'mental deficiency' was defined as "a condition of arrested or incomplete development of the mind existing before the age of 18, whether arising from inherent causes or induced by disease or injury". Four classes of defectives were distinguished, namely 'idiots', 'imbeciles', 'feeble-minded persons' and 'moral imbeciles'. In England and Wales these four groups were redefined by the Mental Deficiency Act, 1927, which replaced the term 'moral imbecile' by 'moral defective'.

218. The Royal Commission on the Law relating to Mental Illness and Mental Deficiency considered that present terminology in England and Wales, as applied to the mentally ill and defective, was often misunderstood and was no longer suitable for every-day use. They recommended the term 'mental disorder' to cover all forms of mental ill-health or disability, and the recognition, for legal and administrative purposes, of three main groups of the mentally disordered, namely mentally ill patients, psychopathic patients or patients with psychopathic personality, and severely sub-normal patients or patients with severely sub-normal personality. We do not yet know whether these new terms will be generally accepted; moreover they will not necessarily apply in Scotland.[1] In our Report we shall use the terms 'mentally ill' and 'mentally defective' in their present sense, and the general term 'mentally disordered' to cover all forms of mental illness or defect, as suggested by the Royal Commission.

219. The Royal Commission used the term 'mental welfare officer' in place of the present term 'duly authorised officer' which, they recommended, should no longer be used since it was not generally understood by the public. They did not envisage, however, that every mental welfare officer employed by a local authority would be permitted to sign applications for compulsory admission to hospital care or guardianship. We shall therefore use the present term 'duly authorised officer', and 'authorised officer' in Scotland, when referring to certification and removal procedure. We use the term 'mental welfare officer' to denote officers in all three countries undertaking work in relation to mental illness and mental deficiency, except when we wish to distinguish between the duties of certain workers or between specific services.

220. Much of the credit for changing public attitudes towards mental disorder is due to voluntary effort which pioneered new forms of care and after-care for both the mentally ill and defective, and helped to bring about a more general recognition of the significance of stress and emotional causes in neurotic symptoms and mental breakdown. In 1936, a voluntary committee under the chairmanship of Lord Feversham undertook a survey of the voluntary mental health services in England and Wales and recommended the formation of a national body to incorporate a number of existing voluntary organisations.

[1] The Mental Health Bill now before Parliament proposes terms for four groups for England and Wales.

A Provisional National Council for Mental Health was set up in 1942, which later became the National Association for Mental Health. In 1944, the Ministry of Health invited the co-operation of the former body in organising an after-care scheme for ex-service personnel discharged from the forces on psychiatric grounds. In each region experienced psychiatric social workers, assisted by selected social workers, supervised the care and after-care of the mentally ill on lines similar to those subsequently envisaged in the National Health Service Acts. After the war a few of these regional offices and their staff were taken over by local authorities and became the basis of a community care service under the National Health Service Acts. The Scottish Association for Mental Health was formed in 1938 by the amalgamation of a number of existing voluntary organisations. It promotes the formation of local associations, and undertakes public education in the importance of mental health.

221. Under the National Health Service Acts local authorities are empowered to provide care and after-care for the mentally ill and defective in combination with the services provided under the Lunacy and Mental Treatment and Mental Deficiency Acts. In outlining the general conception of this service the Minister of Health and the Secretary of State for Scotland suggested[1] that, although it was important that mental health functions should not be dealt with in isolation from other health services, authorities might wish or find it advantageous to establish a mental health sub-committee of the health committee with particular responsibility for the service. Details of these sub-committees as at 1st May, 1956 (as shown in replies to the questionnaire) are given in Appendix D. It was further suggested by the Minister of Health that there should normally be a medical officer on the staff of the medical officer of health competent to advise on mental health matters, and to undertake the medical direction of the mental health social workers. It was recognised that there would be wide scope for the joint use of local authority and hospital staff in community care, to avoid double visiting and to encourage the economic use of trained personnel.

222. Training for psychiatric social work was initiated by the Commonwealth Fund of America, which pioneered the child guidance movement in this country. The mental health course at the London School of Economics was started in 1929; other courses were established at Edinburgh University in 1944, at Manchester University in 1946, and more recently at Liverpool University.

223. There has never been a recognized training or qualification for mental health social workers as distinct from psychiatric social workers. Before the war, short courses were arranged by the Central Association for Mental Welfare for existing workers in the mental health field, and individual arrangements were made for trained social workers going into such work for the first time. Immediately prior to the 5th July, 1948, and for a short time after, the National Association for Mental Health organised a number of short courses for local authority officers transferred, mainly from the former public assistance service, to mental health duties. It has also promoted diploma courses, recognised by local education authorities, for teachers of the mentally handicapped in occupation centres, mental deficiency hospitals, or their own homes.

[1] Ministry of Health Circular 100/47; Department of Health for Scotland Circular 99/47.

224. In July, 1948, the Minister of Health appointed a Committee under the chairmanship of Professor J. M. Mackintosh (the Mackintosh Committee) to consider and make recommendations on the supply, demand, training and qualifications of social workers in the mental health services as a whole, that is, in hospitals and child guidance clinics as well as in local health authority services. The Committee presented an interim report on psychiatric social workers in 1949, and a final report in 1951.[1] We have studied both reports with care, and brought some of the statistical information up-to-date (paragraph 804). Seven years later, we can but echo many of the findings. There is still a large unfulfilled demand for social workers in the mental health services. Psychiatric social workers are still a mere handful in relation to the demand (though the local authority situation has improved slightly, as shown in paragraph 342) and there is still no training for other mental health workers. This is all the more serious in that the scope of the services, and the needs to be met, have grown as the Committee foresaw. Their fears that there were dangers of extensive specialisation in social work without a solid foundation of general practice have also been confirmed, though this is beginning to change as described in paragraph 825.

225. The main recommendations of the Mackintosh Committee were that the standard of training of psychiatric social workers should be maintained, and that there should be a nucleus of such workers supported by social science qualified workers, and a large number of mental health officers. The latter should be in-service trained, and work under an experienced psychiatric social worker or mental health officer. As an urgent measure to improve recruitment the Committee recommended the adoption of a trainee scheme, to be organised through regional hospital boards, under the supervision of experienced psychiatric social workers. The Committee also recommended that the term ' psychiatric social worker ' should be restricted to persons holding a university mental health certificate, and that there should be a register of psychiatric social workers. Other recommendations related to the fuller and better use of part-time workers, particularly married women, the recruitment of men, and the utmost economy of skilled staff by providing clerical and other assistance, proper office accommodation and facilities, and cars in country districts. The detailed recommendations in the interim report covered much the same ground. In addition, it was recommended that efforts should be made to establish additional university courses for psychiatric social workers, and that grants from public funds should be more easily available to suitable candidates wishing to take the social science and mental health courses. Other recommendations in the interim report related to the expansion of courses for mental deficiency workers, and the establishment of a voluntary central consultative committee to achieve common standards in the trainee scheme.

226. The recommendations relating to the use of married psychiatric social workers in part-time appointments, the recruitment of men to the mental health services, the restriction of the term ' psychiatric social worker ' to persons holding a university mental health certificate, and the need for economy in the use of qualified workers were brought to the attention of hospital and local health authorities.[2] Attention was also drawn to the Committee's suggestion of the joint use of senior workers. Beyond this no action

[1] The Committee on Social Workers in the Mental Health Services: Cmd. 8260.
[2] RHB. (50) 5/HMC.(50)5. Circular 6/50.

was taken to implement the recommendations, mainly, we understand, because of doubts as to the wisdom of treating the mental health services separately from other health services, or of setting-up a separate training for mental welfare officers. At the same time the Committees on Medical Auxiliaries[1] were engaged in examining other services likely to draw on the same sources of recruitment, and subsequently a committee considering the field of work of officers in a related service (the Inquiry into Health Visiting) was expected to clarify the role of health visitors in the mental health and mental deficiency services. While appreciating the weight of these considerations, we cannot but deplore the time lost in the years since the Mackintosh Committee stressed the urgency of the situation. Even a series of modest experimental courses in the last few years would have helped newly recruited duly authorised officers and mental welfare officers to undertake the difficult and important work which awaited them, and would also have produced a useful body of experience on which to base recommendations for training. We have much sympathy with the disappointment and frustration felt by these officers who have waited so long and done so much to try to bring about opportunities to train in their chosen field of work.

227. Since the publication of the Mackintosh Report, interested organisations in the mental health field have continued to press for training for mental welfare officers (especially new recruits) which would lead to a recognised qualification. The National Association for Mental Health, in addition to emphasising the need for training, has recently organised refresher courses for existing officers of some years standing to enable them to develop their skill further. We in our turn have taken up the task of considering appropriate training but in accordance with our terms of reference have set it against the background of the health and welfare services as a whole.

228. Various aspects of the mental health services provided by local health authorities in Scotland have been reviewed in recent years as noted in paragraph 214. The Report of the Committee on the Scottish Lunacy and Mental Deficiency Laws[2] proposed no material alteration in the existing provisions relating to the boarding out of persons suffering from mental illness. It was noted, however, that some defectives not subject to be dealt with under the Mental Deficiency Acts would benefit from supervision by appropriate officers of the local health authority, or a suitable voluntary organisation. It was accordingly proposed in the White Paper[3] that besides the duty to provide training and occupation under Section 51 of the National Health Service (Scotland) Act, 1947, local health authorities should have a duty to arrange for the supervision of such defectives where necessary or desirable, either directly or through voluntary organisations. In 1957 the Scottish Health Services Council published a Report on Mental Deficiency in Scotland which recommended the further development of the community care services for certified mental defectives. The Scottish Advisory Council for the Welfare of Handicapped Persons (see paragraph 263) has also reviewed these services and recommended an expansion of the welfare services for both the mentally ill and defective.[4] No specific recommendations have been made in these reports or in the White Paper regarding the type or qualifications of local

[1] Cmd. 8188. [2] Cmd. 6834. [3] Cmd. 9623.
[4] Department of Health for Scotland Circular 17/1957.

authority staff to be employed in the Scottish mental health services. So far as social workers are concerned, the needs to be met and the proposals for future development imply (as in England and Wales) the employment of fully trained staff.

229. The services in England and Wales will be greatly affected if the recommendations of the Royal Commission on the Law relating to Mental Illness and Mental Deficiency[1] are implemented. The general principle of the Royal Commission's Report is that the treatment of the mentally ill should, as far as possible, be on the same basis as that of the physically ill, and admission without legal formality and without power to detain should normally be the accepted procedure. Community care and hospital treatment should be available to all who wish to use them, without compulsion or formal ascertainment. We welcome this general approach, and the spirit of the Royal Commission's recommendations. We also welcome the general trend away from institutional care in its present form and the emphasis on care in the community. The implications, in terms of staffing, have, however, added greatly to our own task, and to the complexity of the general problem of estimating future staffing needs in England and Wales. The Royal Commission recognised that local authorities would have to employ more social workers if they were to be fully responsible for the after-care of hospital patients and the social care of those not requiring admission to hospital ; they expected that we should take into account their proposals for community care in considering the recruitment and training of mental welfare officers. They also noted that the recruitment of staff for residential homes and hostels would not be easy.

230. It is indeed difficult to see how a rapid and substantial expansion of staff, suitably equipped to meet the demands of the service, can be achieved in present circumstances. The Royal Commission recognised that in many areas the existing services had a considerable leeway to make up compared with some other parts of the health and welfare services, and felt it right to assume that a fair share of the national resources would in future be allocated by central and local government to these services. They also considered that if local authorities were to resume and develop some of the responsibilities relinquished to the hospital service in 1948 they had a claim to as much help as could reasonably be given. We trust that our proposals in the chapters on Recruitment and Training will be considered in the light of these suggestions.

231. The Royal Commission also recommended that local authorities should provide residential accommodation for the mentally ill (including the elderly mentally infirm), and severely sub-normal and psychopathic patients who, for various reasons, require residential care but do not need hospital in-patient treatment. The Committee on the Rehabilitation, Training and Resettlement of Disabled Persons (the Piercy Committee), in discussing the needs of the mentally handicapped group (i.e. high grade mental defectives and persons recovering from psychoses or neuroses) who are employable but need after-care and help in resettlement, similarly recommended that local authorities should experiment in the provision of hostels for such persons undergoing industrial rehabilitation or training or on first entering

[1] Cmnd. 169.

employment.[1] Many different types of accommodation, with appropriately trained staff, will be required if these recommendations are generally implemented.

232. The Royal Commission took the view that the central direction of the community care services should be the responsibility of the medical officer of health. They thought it essential that he should take a personal interest in the services and have suitably experienced medical officers and social workers on his staff. They also recognised that one of the most important functions of the local authority social worker or mental welfare officer was to try to ensure that the patient's family understood his needs and difficulties. They regarded it as a normal part of the local authority's community care services for these workers to undertake social work for the patient's family while he was yet in hospital, and to keep in touch with the hospital and report on home circumstances. The Report concluded that: "social work for patients who are not receiving hospital treatment, including patients who have left hospital, is essentially the responsibility of the local authorities. They can also do a great deal in co-operation with the hospital staff for hospital out-patients and even for in-patients."[2]

233. It is difficult to estimate even roughly the number of mentally disordered persons needing care from local authority services. Hospital discharges in England and Wales in 1957 amounted to 82,778 of whom 19,643 were classified as recovered, 54,054 as relieved and 8,822 as not improved. In Scotland 9,259 patients were discharged, but a similar analysis has been made only of the 2,071 among these who were certified patients, of whom 1,362 were classified as recovered, 608 as relieved and 79 as not improved. No figures are available of the number at present receiving after-care in the community. There has been a marked increase of recent years in out-patient attendances for mental deficiency and mental illness, which in 1957 were 833,764 in England and Wales (775,228 in 1956, and 714,014 in 1955) and 32,266 in Scotland (26,608 and 24,708); and also in the number of domiciliary visits made by psychiatrists which in 1957 were 22,406 in England and Wales (18,416 in 1956 and 11,299 in 1955), and 2,633 in Scotland (2,731 and 1,759). The numbers of mentally ill patients in hospitals, on the other hand, decreased slightly from 149,480 in England and Wales and 20,855 in Scotland on 31st December, 1956, to 146,962 and 20,736 on 31st December, 1957.

234. The Royal Commission on the Law relating to Mental Illness and Mental Deficiency commented that:—"Various estimates have been made of the incidence of mental illness, or of particular types of mental illness, on the basis of the investigation of a particular area or of some group of people who may be regarded as a typical or random sample of the population. Each investigator has first had to decide what forms or degrees of illness are to be the subject of his survey, and by what criteria he will define them. One investigator has rarely adopted exactly the same criteria as any other, and while each investigation brings out points of interest it is difficult to judge how far one supports another or to draw any general conclusions from them. It has, for example, been estimated that about 10 per cent of the patients seen by general practitioners are suffering from psycho-neurosis, mostly of a mild character. Other general practitioners, each adopting his own criteria of

[1] Cmd. 9883, paragraphs 295–296.
[2] Cmnd. 169, paragraph 603 (iii).

the type of illness of which his survey takes cognisance, have estimated the proportion of neurotic patients in their practices at figures varying from 2 per cent to 70 per cent. A survey of a sample of adult male and female workers in engineering factories in war-time showed that 10 per cent of the workers had suffered from "definite and disabling neurotic illness", and a further 20 per cent from "minor forms of neurosis", during the course of six months; "neurotic illness" caused between a quarter and a third of all absence from work due to illness, in the group of workers studied."[1]

235. The most recent estimate of the incidence of mental illness is based on a study of the sickness experience in the 12 months of May 1955 to April 1956 of 382,829 persons on the lists of 171 general practitioners in 106 representative practices in England and Wales. The rate of 2·2 per thousand persons diagnosed as suffering from psychoses suggests in the opinion of the authors a national total of 100,000 patients under medical practitioner care at some time during the year, exclusive of those in hospital throughout the year. Prevalence of psycho-neurotic disorders at each age including childhood was found to be higher in females than males. The total consultation rate indicated that 1 in every 15 patients who consulted their doctor, and 1 in 20 of the total patients under survey, was recorded as suffering from psycho-neurosis.[2] The rate of 45·7 per 1000 of patients diagnosed as suffering from psycho-neuroses suggests a national total of over 2 million under general practitioner care in any one year.

236. The Royal Commission also referred to estimates made of the incidence of mental deficiency in the general population of England and Wales after a detailed investigation of six areas in 1925–27. "It was then estimated that of every 10,000 of the population about 80 were mentally defective in the sense that at some period of their lives they would require the type of care which should be provided under the Mental Deficiency Acts. It was estimated that among each 80 defectives, 4 were idiots, 16 imbeciles and 60 feebleminded. Any estimate of the number of persons who may require care from the special mental health services is affected by the extent to which general social conditions, such as full employment and general social welfare services, make it possible for persons suffering from mild degrees of mental disability to manage in the general population without special care, and by the degree of administrative separation or integration of mental health services and other social services which is thought desirable at any period. An estimate made in 1929 might not be equally applicable in 1956. These considerations are much less likely to affect the estimate of the incidence of severe forms of mental sub-normality."[3]

237. On 31st December, 1957, 3,857 of the 56,990 defectives in mental deficiency hospitals in England and Wales were on licence; in Scotland 415 were on licence out of 5,650. Local authorities in England and Wales were responsible for 60,388 mental defectives under statutory supervision, 17,924 under voluntary supervision, and 2,479 under guardianship: in Scotland 2,511 mental defectives were under guardianship in terms of the Mental Deficiency (Scotland) Act.

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[1] Cmnd. 169, page 309.

[2] General Register Office, Studies on Medical and Population Subjects No. 14 (1958): Morbidity Statistics from General Practice, Volume I (General) by W. P. D. Logan, M.D., Ph.D. (Chief Medical Statistician, General Register Office) and A. A. Cushion, of the General Register Office.

[3] Cmnd. 169, pages 309–310.

238. The earliest reference to the home help service is found in the Maternity and Child Welfare Act, 1918, under which local authorities in England and Wales were empowered to appoint home helps to assist in the home during a mother's lying-in period. Recognition of this need came, as we have indicated in paragraph 190, as a result of changing social conditions after the first world war, and the general desire to reduce infant mortality, but the impetus may be traced to the Midwives Act of 1902 which prohibited the attendance for gain of untrained persons on lying-in women. This prohibition brought about a gradual decline in the traditional occupation of 'handy-woman', an occupation which encompassed not only attendance during delivery but also the care of the home and family during the lying-in period. The Act introduced the certificated midwife but left a gap in the provision of supportive care to underpin the benefit of her trained services.

239. The former handywoman was not the sole forerunner of the present-day home help. In a less complex society and with a more extended family unit such help was usually given spontaneously as need arose by relatives or neighbours, usually in a voluntary capacity. Today individuals or families are still supported by the practical help of relatives or neighbourhood groups in time of crises, or even over a longer period of physical illness or social inadequacy. But generally in our more differentiated society, especially where there is much mobility, and women work outside the home, relatives or neighbours are no longer so easily available to help each other in time of difficulty. To meet this situation the home help service has developed as an integral part of the social services, and now covers a wide range of need for practical help in the home.

240. In elaborating the provisions of the Maternity and Child Welfare Act, 1918, the Local Government Board suggested[1] that home helps should be "persons of suitable character" and outlined their duties as being those domestic duties usually undertaken by the mother, including the care of children, cleaning, cooking, washing, mending and marketing. Training courses, varying from one to three months, were advised. The powers to provide help during the lying-in period were continued under the Public Health Act, 1936, and extended in 1942 to include, where necessary, the ante-natal period and (at the discretion of the maternity and child welfare authority) "such other types of care as local circumstances may suggest". In 1944 the general powers were extended by Defence Regulations to include the provision of domestic help to sick and infirm persons, and in other circumstances, as for example when a housewife was suddenly called away to her husband in hospital and arrangements had to be made to look after the children, or where several members of a family were ill at the same time. A number of authorities established services under one or both of these powers, which tended however to be regarded as two separate schemes for administrative purposes though often drawing on a common pool of workers. In 1946 the Minister of Health[2] drew the attention of local authorities to the lack of services in many areas, noting also that some had proved inadequate to meet local needs, mainly because of insufficient home helps. The appointment of a full-time organiser was suggested since

[1] Local Government Board Circular, 9th August, 1918, paragraph 28.
[2] Ministry of Health Circular 110/46.

the successful provision of a service depended largely on her enthusiasm and resourcefulness in overcoming the difficulties inherent in the general shortage of woman power.

241. The powers enabling local authorities to provide home helps under the Public Health Acts, and domestic help under Defence Regulations, were superseded in 1948 by the permissive powers under the National Health Service Acts. All local authorities in fact provide this service, for which charges may be made. The Minister of Health, in outlining the duties of local health authorities under the Act (in particular those relating to the care of mothers and young children, domiciliary midwifery, home nursing and the care and after-care of persons suffering from illness), pointed out that the effectiveness of these other services would be seriously hampered without an adequate and efficient home help service.[1]

242. There is at present no training for home help organisers but the Institute of Home Help Organisers has made efforts to promote this and has organised short refresher courses. Between 1948 and 1950 the Women's Voluntary Services provided short courses for newly appointed organisers. The staffing of this service is set out in paragraph 350 ; the present picture is described in paragraphs 478 to 483.

SERVICES PROVIDED UNDER THE NATIONAL ASSISTANCE ACT, 1948

243. The National Assistance Act completed the break up of the Poor Law by transferring to the central government, acting through the National Assistance Board, responsibility for financial assistance to persons in need, and for the provision of re-establishment and reception centres for persons without a settled way of life. These took the place of the casual wards under the Poor Law. In practice a few authorities provide reception centres on behalf of the National Assistance Board, but the staff concerned are outside our terms of reference except in so far as they may have functions in other services. The Children Act, 1948, placed responsibility for children deprived of a normal home life on newly created children's committees.

244. Thus at the present day the main functions of councils of counties and county boroughs in England and Wales and of counties and large burghs in Scotland under the National Assistance Act are :

(1) The provision of residential accommodation, either directly or through voluntary organisations, for persons who by reason of age, infirmity or any other circumstances are in need of care and attention not otherwise available to them, and the provision of temporary accommodation for persons who are in urgent need thereof, being need arising in circumstances which could not reasonably have been foreseen. (Section 21 (1) (*a*) and (*b*)).

(2) The promotion, either directly or through voluntary organisations, of the welfare of persons (including children) who are blind, deaf or dumb, or substantially and permanently handicapped by illness, injury or congenital deformity or such other disabilities as may be prescribed. (Sections 29 and 30.)

[1] Ministry of Health Circular 118/47, paragraph 52.

The powers provided by Section 29 are permissive except to such extent as they are made a duty. At present only the welfare of the blind is a statutory duty, continuing that under the Blind Persons Acts, repealed by the National Assistance Act.

245. Section 31 enables local authorities to contribute to the funds of voluntary organisations providing facilities for old people living in their own homes, so long as these include the provision of recreation or meals. Other provisions of the Act require local authorities to look after the effects of persons admitted to hospital or other establishments where such action appears necessary, and empower them to seek an order of court for the removal to hospital or other accommodation of persons in serious ill health and living in insanitary conditions without proper care.

ADMINISTRATIVE STRUCTURE

246. Under the Poor Law, local authorities had a statutory duty to establish a public assistance committee, and also to appoint a public assistance officer and other senior Poor Law officials. Before the passing of the National Assistance Act local authorities were advised[1] that they could either arrange for functions under the Act to be dealt with by a new committee, or apply for a direction that these functions should be the responsibility of an existing committee, e.g., the health committee, or that some should be dealt with by an existing committee leaving others to be referred to the new committee. This new committee should be so named as to emphasise the break with the public assistance service, and the titles of welfare committee or welfare services committee were suggested. If it were decided, in local circumstances, to employ the health committee instead of establishing a new committee the Minister of Health suggested that the administrative arrangements should observe the distinction between the health and welfare services, and the advantages of remitting the latter to one or more sub-committees. It was further suggested that the welfare services should as far as possible be administered by lay (that is non-medical) staff and that consideration should be given to the appointment of a senior lay officer to direct the administration of the service subject, except in special circumstances, to the general oversight and responsibility of the medical officer of health.

247. On the whole the arrangements made at that time have not greatly altered. The committee structure of the welfare services as at 1st May, 1956 (as shown in replies to the questionnaire) is set out in Table 36. It will be seen from this table that the pattern suggested has been followed by the majority of authorities. Seventy-five per cent of authorities in England, Wales and Scotland have separate welfare committees, to which 70 per cent have remitted all the welfare services, and 5 per cent all services other than the services for the handicapped, which are administered by the health committee. In 17 per cent of authorities in England and 6 per cent in Wales the welfare services are administered by the health committee through a welfare sub-committee. In Scotland 20 per cent of authorities have a joint health and welfare committee, without a welfare sub-committee. Further information on the patterns of administrative responsibility in England, Wales and Scotland is given in Appendix D. Details of the staff within our terms of reference employed in these services are set out in Chapter 2.

[1] Ministry of Health Circular 70/48; Department of Health for Scotland Circular 38/1948.

Domiciliary Services

248. For convenience, we consider the care of the elderly (whether in their own homes or in residential accommodation) in this section, though important domiciliary services are provided under the National Health Service Acts. These include medical care and treatment by general practitioners, and the local health authority home nursing and health visiting services. Local health authorities may also provide home helps and arrange for the care of elderly sick people at home and on discharge from hospital. Under the National Assistance Act, local authorities have a duty to provide residential accommodation for those in need of care and attention not otherwise available to them. They have powers under Section 31 of that Act to contribute to the funds of voluntary organisations whose activities include the provision of recreation or meals. The welfare of older people in their homes must be ensured by the co-ordinated use of the resources available under the National Health Service and National Assistance Acts, including the voluntary services, since there are no powers in either Act equivalent to those in Section 29 of the National Assistance Act which promote the welfare of handicapped persons.

249. Since 1948, circulars[1] from the Ministry of Health and the Department of Health for Scotland have drawn attention to the need for close collaboration between local authorities and voluntary organisations in ensuring the satisfactory care of older people in the community, and also to the range of help which may be required from health, welfare, and housing departments, voluntary services and good neighbours. It was recognised that the great majority of elderly people preferred to remain in their own homes, but that many could only do so in reasonable comfort with help and interest from outside. The circulars emphasised the importance of regular visiting and of personal services provided by volunteers, and also of a two-way flow of information so that the appropriate services were notified of specific needs. It was further suggested by the Minister of Health that this exchange of information should normally be canalised through the welfare department, in co-operation with local voluntary organisations.

250. The development of voluntary services for the elderly, and the co-ordinating work of national and local old people's welfare committees provide a heartening demonstration of the continuing vitality of voluntary effort. There are now 1,280 local old people's welfare committees in England and Wales, and 247 in Scotland. The National Old People's Welfare Council and the Scottish Old People's Welfare Committee act as co-ordinating bodies, and promote the setting up of new committees and organise training and refresher courses. Services are also provided by other voluntary organisations, including the British Red Cross Society, the Women's Voluntary Services and (to a limited extent) the National Corporation for the Care of Old People. Many useful experiments have been pioneered by voluntary effort to which further reference is made in paragraphs 485 to 486. These services are of particular significance in preventing mental and physical deterioration, and in enabling older people to maintain their independence for as long as possible.

251. It is well known that the number of elderly people has been increasing for some years, both absolutely and in proportion to total population. The census of 1951 showed that nearly a million old people were living alone,

[1] Ministry of Health Circular 11/50; Department of Health for Scotland Circular 60/1958.

double the number in 1931. Figures from the Registrar General's Statistical Review of England and Wales for selected years (which are set out in Table 1) show a marked increase at ages over 65, and especially in the older groups whose need for health and welfare services is likely to be greatest. This trend is expected to continue for at least a further two decades. Projections taken from the Registrar General's Statistical Review of England and Wales for 1956 are also included in Table 1. These projections are based on the assumption, as regards mortality, that at ages under 45 death rates would decline steadily over the next 25 years to about half of present rates, and that at ages over 45 the assumed rates of decline would become progressively smaller as age advanced.

252. The actual number of elderly people is already considerable. In 1955 there were 267,000 men and 496,000 women in England and Wales over the age of 80—more than twice the number in 1935—and 3,241,000 over the age of 70. In Scotland, where the same trends could be observed, figures from the Annual Report of the Registrar General for Scotland show that in 1955 there were 28,000 men and 47,000 women over the age of 80, and 331,000 persons over the age of 70.

Table 1: Estimated population in given age ranges (England and Wales) including projections up to 1986

Year	Men in age ranges (expressed in thousands)					Women in age ranges (expressed in thousands)				
	65–69 years	70–74 years	75–79 years	80–84 years	85 years and over	65–69 years	70–74 years	75–79 years	80–84 years	85 years and over
1935 ...	643	421	231	98	35	761	544	335	164	72
1940 ...	724	487	259	110	40	869	631	390	194	87
1945 ...	772	558	322	138	60	973	721	463	239	122
1950 ...	784	596	373	169	68	1,029	812	534	278	145
1955 ...	785	596	385	189	78	1,082	880	617	329	167
Actual increase 1935–55	142	175	154	91	43	321	336	282	165	95
Percentage increase 1935–55	22	42	67	93	123	42	62	84	101	132
1961 ...	821	606	392	198	85	1,157	934	674	390	200
1966 ...	936	638	404	203	89	1,248	996	715	422	230
1971 ...	1,092	735	430	212	92	1,352	1,082	770	453	254
1976	1,157	863	500	228	96	1,402	1,180	845	494	276
1986 ...	1,077	906	634	320	122	1,311	1,225	975	607	336

Residential accommodation

253. The statistics in Table 1 are reflected in the numbers seeking residential care, and in the increasing infirmity of those admitted. The figures provided annually by the Ministry of Health and the Department of Health for Scotland show that on 5th July, 1948, the number of men and women of all ages in residential accommodation (including those in accommodation provided on behalf of local authorities by voluntary organisations) was 46,337 in England

and Wales and 6,089 in Scotland. The comparable figures in 1957 were 76,779 and 6,596. The annual returns made by local authorities show that by 31st December, 1957, more than 56 per cent of the elderly in residential care were being cared for outside the former institutions. Since the end of the war, 996 new homes accommodating 30,800 residents had been opened by local authorities in England and Wales, and 87 new homes accommodating 2,298 residents in Scotland. This revolution in the type of accommodation provided has sometimes gone unnoticed because of long waiting lists and continued pressure for admission, and the greater emphasis now placed on the care of the elderly in their own homes if these are suitable.

254. The nature of the care provided has also changed. It is unnecessary for our purpose in this chapter to linger on the history of institutional care under the Poor Law, or to consider the provision of temporary accommodation which, in the form conceived by the National Assistance Act, had not hitherto existed (see paragraphs 498 to 509). On 5th July, 1948, the residential services under the National Assistance Act inherited those Poor Law establishments which had not become outright a part of the National Health Service hospital service, and a share on a joint-user basis of a considerable number which would ultimately be absorbed by either hospital or local authority service. The new service, and those responsible for administering it, also inherited all the accumulated backlog of overdue modernisation of premises at a time when many post-war restrictions on building and capital expenditure were still in force. The residential staff passed in one day from the well-documented routine and long-established tradition of the Poor Law to a new service which aimed at providing a substitute for a normal home life for a wide range of individuals, the criterion for whose admission was simply that they were in need of care and attention not otherwise available to them. The tremendous task imposed on local authorities is still incomplete. It would have been even more difficult without the voluntary homes for old people which already existed, and the enterprise of some voluntary organisations in providing new ones and in experimenting in new types of care. In many instances these pioneer schemes were financially assisted by the National Corporation for the Care of Old People.

255. Training and refresher courses for wardens and matrons and assistant matrons of old people's homes have been provided for some years by the National Old People's Welfare Council and the Scottish Old People's Welfare Committee. The present picture of both domiciliary and residential services is described in paragraphs 484 to 509.

SERVICES FOR THE HANDICAPPED

General

256. The development of the welfare services for the handicapped conforms closely to the traditional pattern of pioneer work by few individuals or organisations followed by the gradual participation of local authorities as legislation made this possible.

257. So far as the blind and deaf are concerned, it seems clear that those who first tried to help in an organised way saw the prime needs as education and training, employment and spiritual ministration. These were indeed basic needs when the alternative was to live in poverty and idleness, often

as a heavy family burden, in a world where not to work was to forfeit social esteem, and to exist in constant fear of the workhouse. Even more important, perhaps, was spiritual ministration, giving a sense of worth and value, a meaning to the existence of those who must often have felt their lives a disaster to themselves and their families. The 'cripples' parlours' of a later day and the many group activities for the blind came into existence by degrees alongside the tremendous growth of leisure activities in the nineteenth and early twentieth centuries as hours of work were shortened and a less puritan attitude permitted working people some enjoyment of each other's company.

258. The first statutory services for the handicapped were educational. From the 17th and 18th centuries onwards it was recognised that children with certain handicaps required special help. Some of the early pioneers considered the first need was to educate blind and deaf children so that they might read and understand the Bible; to others the aim was to avoid care under the Poor Law. The first schools for the blind and deaf were founded by voluntary effort in the latter half of the 18th century, and those for crippled children and mental defectives towards the middle and end of the 19th century. The first real step towards a statutory service followed the recommendations of the Royal Commission on the Condition and Education of the Blind and the Deaf and Dumb in the United Kingdom which reported in 1889. Education Acts in England and Scotland subsequently empowered school authorities, and later local education authorities, to make special provision first for the blind and deaf, later for mental defectives and epileptics, and eventually for ten categories of children for whom special schools must be provided, namely the blind, the partially sighted, the deaf, the partially deaf, the delicate, the educationally sub-normal, the epileptic, the maladjusted, the physically handicapped and those with speech defects.

259. Thus special educational provision is intended to give handicapped children an education similar to that of other children and to equip them to take their place, to such extent as is possible, as self-reliant and responsible members of the community. In the course of time there has been a steady development of appropriate medical care, vocational training and guidance and help from the employment services. Many handicapped children are able as they grow up to become, and remain, independent. In our inquiry we have been concerned mainly with those who need either temporary or continuous help from the health and welfare services in childhood or adult life, and with those who because of the severity of their disability present special problems.

260. Services for handicapped adults have a similar though less lengthy tradition. Voluntary effort for the blind aimed at providing a comprehensive service from the cradle to the grave. Its success may be judged by a wide range of services for general care and visiting, education, training, employment in sheltered or open industry, and residential accommodation. Services for the adult deaf owed their origin to the recognition of spiritual needs, and the difficulties of deaf people in obtaining employment and enjoying social intercourse. Until comparatively recently the main emphasis in voluntary effort for the physically handicapped was on medical treatment and employment, and the importance of helping to alleviate personal and social difficulties was less generally recognised.

261. There was no statutory provision for the welfare of handicapped adults other than the blind until the National Assistance Act, 1948. The "necessary relief of the lame, impotent, old and blind" is referred to as one of the basic purposes of early Scottish Vagrancy Acts and the Elizabethan Poor Law but without exception this was limited to undifferentiated institutional care or outdoor relief until the Blind Persons Act, 1920, made provision for some of the blind outside the Poor Law. Thereafter these particular services developed along specialist lines, and it was not until two world wars had helped to focus public and political interest on the importance of utilising all available manpower, and of hastening the re-establishment in the community of war-disabled civilians and ex-servicemen, that a trend towards more general care of the handicapped and disabled can be discerned.

262. The emphasis on concerted medical, social and industrial action in the Report of the Interdepartmental Committee set up in 1941 (the Tomlinson Committee)[1] to study the rehabilitation, training and resettlement of the disabled marked a new approach to the problems of the physically handicapped. While the National Health Service Acts made no specific provision for the handicapped as such, the general development of hospital rehabilitation services since 1948 has greatly altered the medical outlook for many handicapped persons. Earlier ascertainment and diagnosis, new methods of medical and surgical treatment of certain diseases and disabilities, and the special rehabilitation services which help to speed recovery, may well change the present picture of adult disability within the next generation or two. The pioneer work of voluntary organisations, such as the British Red Cross Society and the Central Council for the Care of Cripples, in providing gadgets and other aids to living to mitigate the effects of severe disablement, and the emphasis now placed on this aspect of rehabilitation by some hospitals, has greatly increased the degree of independence which can be achieved, especially by disabled housewives. The greater awareness and understanding of the stresses experienced by a disabled person and his family, and the consequent problems of adjustment, is shown by the demand for almoners in the hospital service and for appropriately trained workers in the local authority services.

263. The circulars[2] issued by the Ministry of Health and the Department of Health for Scotland setting out the scope of the welfare services under the National Assistance Act emphasised that the type of help required by individual handicapped persons would vary according to the nature of the handicap and the degree of personal adjustment achieved. The guiding principle of the service should be "to ensure that all handicapped persons whatever their disability should have the maximum opportunity of sharing in and contributing to the life of the community so that their capacities are realised to the full, their self-confidence developed, and their social contacts strengthened. The provision of skilled advice and help will in most instances be the pre-requisite to the achievement of this aim". In order to assist local authorities with the development of these services the Minister of Health and the Secretary of State for Scotland appointed Advisory Councils for the Welfare of Handicapped Persons to advice on matters relating

[1] Report on the Interdepartmental Committee on the Rehabilitation and Resettlement of Disabled Persons. Cmd. 6415. H.M.S.O., 1943.
[2] Ministry of Health Circular 87/48; Department of Health for Scotland Circular 51/1948.

to the welfare of persons for whom the services are provided. Both these bodies are represented on our Steering Committee. They have advised Ministers on the development of the services generally and issued reports on special subjects, to which reference is made in paragraphs 228, 299 and 300. The Ministry of Health Advisory Council (which was reconstituted in 1957 as the Advisory Committee on the Health and Welfare of Handicapped Persons) took the place of the former Advisory Committee on the Welfare of the Blind. In 1953, a sub-committee of the Council considered the training and qualifications appropriate to welfare officers in the new services and drafted a report to which we refer in paragraph 302.

264. The services envisaged under the National Assistance Act apply with necessary modifications to the blind and partially sighted, the deaf and hard-of-hearing, and the general classes of handicapped persons. They include:

(*a*) the ascertainment of handicapped persons;

(*b*) assistance in overcoming the effects of their disabilities and arranging for the provision of such treatment as may be required;

(*c*) advice and guidance on personal problems;

(*d*) instruction in handicrafts and simple diversionary occupations, and the teaching of the blind to read embossed literature;

(*e*) the provision of social and recreational facilities;

(*f*) home visiting and practical assistance in the home;

(*g*) facilities for transport and holidays;

(*h*) assistance in securing employment in open industry, and the provision of sheltered employment in special workshops and under home worker schemes.

Local authorities using their permissive powers under the Act are therefore able to plan comprehensively for all three categories of handicapped persons. They can thus ensure continuity of care of the severely handicapped school leaver, and co-operate with and, where necessary, take over from the care and after-care services under the National Health Service Acts. The present development of these services is described in Chapter 3. It is desirable to consider first a brief sketch of the background to each of the main services.

(a) The blind and partially sighted

265. Blindness has always made a special appeal to voluntary effort, possibly because most people find it less difficult to imagine a life without sight than a world without speech or sound, or to comprehend the effects of severe physical disability. The services for the blind have had a long start compared with other services under the National Assistance Act. They have also the distinction of providing the first home visiting service, organised by the Indigent Blind Society in London in 1856. Originally the purpose of visiting was to read the Bible to the blind, write letters for them and so forth: later the teaching of reading in embossed literature and simple pastime occupations also came to be regarded as one of the home visitor's functions. This is the historical background to the present day home teachers' duties.

266. Statutory provision in the early part of the 20th century related mainly, as we have seen, to education but in 1917 the Local Government Board appointed an Advisory Committee on the Welfare of the Blind to review and advise on current services. In 1919, following a recommendation by this

Committee, direct Exchequer grants were made under Ministry of Health regulations to approved voluntary organisations undertaking specific services for the blind. The title of home teacher of the blind was first used in these regulations and home visitors have since been known by this name. The Blind Persons Acts, 1920 and 1938, provided for non-contributory old age pensions for the blind to be paid at the age of 40 instead of 70 and placed a duty on the councils of counties and county boroughs, and large burghs in Scotland, to promote the general welfare of the blind. The 1938 Act removed assistance to the blind and their dependents entirely from the Poor Law (other than medical assistance or institutional care, if suitable arrangements were not otherwise available) and redefined the duties of local authorities. Generally speaking, a comprehensive service provided for the certification, registration and classification of the blind, the education and training of children and young persons (through the local education authority) and (usually by delegation to a voluntary organisation) training and employment in workshops or home worker schemes, augmentation of wages, domiciliary financial assistance, hostels for blind workers, homes for the blind and a home visiting or home teaching service. Ten years later, the National Assistance Act, 1948, in continuing the duty of local authorities to provide welfare services for the blind (other than financial assistance, which became a function of the National Assistance Board) also empowered them for the first time to provide similar services for the partially sighted.

267. The statutory definition of a blind person under the National Assistance Act is a person "so blind as to be unable to perform any work for which eyesight is essential". There is no statutory definition of partial sight but the Minister of Health and the Secretary of State for Scotland have advised[1] that a person who is not blind within the meaning of the Act of 1948 but who is nevertheless substantially and permanantly handicapped by congenitally defective vision, or in whose case illness or injury has caused defective vision of a substantial and permanently handicapping nature, is broadly within the scope of the welfare services for blind persons.

268. All local authorities in England, Wales, and Scotland have approved schemes for the blind, and all authorities in England save one also have schemes for the partially sighted, though these are less well developed. Authorities may, if they so desire, provide blind welfare services by agency agreement with a registered voluntary organisation. There are now some 150 of these organisations : in England and Wales there are also four Regional Associations whose functions are mainly consultative and advisory. These Associations keep the regional registers of blind persons, which form the basis of the national statistics, and three of them provide training or refresher courses. The Scottish National Federation for the Welfare of the Blind carries out broadly similar functions in Scotland and is represented on the Inter-Regional Committee of the Associations. A number of other voluntary organisations are concerned with general or specific aspects of the welfare of the blind.

269. The examination of the College of Teachers of the Blind for the home teaching certificate dates from 1919, when the Advisory Committee on the Welfare of the Blind drew attention to the need for training and a recognised qualification. Since 1923 it has been a condition of appointment that

[1] Ministry of Health Circular 150/48; Department of Health for Scotland Circular 7/1949.

unqualified officers should sit for the examination within two years. This examination preceded any formal training by some years. The present training courses date from 1940 when the Southern Regional Association for the Blind established a four months full-time course. The North Regional Association later extended their existing course and finally both Associations, and in Scotland the Society for the Welfare and Teaching of the Blind in Edinburgh and South East Scotland, and the Glasgow and West of Scotland Mission to the Outdoor Blind provided courses covering an academic year.

270. The satisfactory employment of a blind person is of major importance. A special placement service for the blind was first provided in 1941 by St. Dunstans; in 1942 the Royal National Institute for the Blind started a similar service for civilian blind which is used by many local authorities on an agency basis. Since then a number of authorities have themselves appointed placement officers mostly on a part-time basis, that is, the duties may be combined with other functions in the blind welfare service. In Scotland the Ministry of Labour and National Service has appointed an experienced disablement resettlement officer with particular responsibility for blind persons seeking ordinary employment. The Committee on the Rehabilitation, Training and Resettlement of Disabled Persons (the Piercy Committee) recommended that the Ministry of Labour and National Service should assume full responsibility for the placement service and should normally provide it direct, thus relieving local authorities of their present responsibilities.[1] We understand that the present arrangements are likely to continue for the next few years but we have, nevertheless, regarded placement officers (and superintendents of blind workshops) employed by the local authority as outside our terms of reference.

271. A number of home teachers who are themselves blind are employed in the services particularly in Scotland. The Working Party on the Employment of Blind Persons, which reported in 1951, while recognising the difficulties involved in covering areas of scattered population, and in inability to drive a car, recommended that wherever a number of qualified home teachers were employed, a proportion should be blind, provided that they had the right personal qualities and the requisite degree of independence to undertake the work.[2] This recommendation was supported by the Minister of Health and the Secretary of State for Scotland[3] who expressed the hope that local authorities would give it serious consideration in making future appointments.

272. Traditionally the care of the deaf blind, and of those with more than one handicap including loss of sight, has been the responsibility of home teachers of the blind working in co-operation with the voluntary organisations for the deaf. The examination for the home teaching certificate includes, as a compulsory subject, knowledge of the facilities available to deaf blind persons and the ability to converse with them by the manual method. The Report of the Ministry of Health Advisory Council for the Welfare of Handicapped Persons on the Special Welfare Needs of Deaf Blind Persons[4] noted that numerically the problem was small but that such persons suffered much loneliness and frustration. There were estimated to be about 2,500

[1] Cmd. 9883, paragraph 273.
[2] H.M.S.O., 1951, paragraphs 209–210.
[3] Ministry of Health Circular 8/52; Department of Health for Scotland Circular 31/1952.
[4] H.M.S.O., 1951.

deaf blind in England and Wales in 1951 ; 2,998 were registered as such on 31st December, 1957. The Advisory Council accepted the view that the home teacher should in general continue to be responsible for work with the deaf blind, and advocated the appointment of a qualified and experienced home teacher to co-ordinate the work of other home teachers in areas where the numbers of deaf blind justified a special appointment. The report emphasised the great stress under which deaf blind people lived, and made a number of suggestions for promoting contacts with the outside world. The Council also expressed the view that where special educational facilities could not at present be provided and children remained at home, often in unsatisfactory conditions, they should properly fall within the responsibility of the welfare authority.

273. Comprehensive statistics relating to the number and categories of blind persons and to education, training and employment are published annually by the Ministry of Health and the Department of Health for Scotland. The total number of blind persons in various age groups registered in England and Wales at 31st December, 1957, and in Scotland on 31st March, 1957, is shown in the accompanying table, together with numbers newly registered in the previous 12 months, and the numbers in residential care.

Table 2: Total number of blind persons registered

	England and Wales (as at 31.12.57)		Scotland (as at 31.3.57)	
	On blind register	Newly registered in past 12 months	On blind register	Newly registered in past 12 months
Total	96,766	11,288	9,909	1,258
Children under 16 years	2,299	230	237	38
Adults 16–64 years	31,646	1,976	3,944	304
65 years of age and over	62,790	9,069	5,728	916
Age not specified	31	13	0	0
	Number of these in residential care		Number of these in residential care	
Total	6,684		447	
Local authority homes	5,784		347	
Voluntary homes	900		100	

274. In England and Wales 21,320 registered blind persons (22 per cent of the total) were deaf blind or otherwise multiply handicapped. Registers of the partially sighted have been kept in England and Wales only since 1952 : 21,627 persons were so registered on 31st December, 1957.

275. There has been a steady increase in recent years in the blind population in England and Wales and in new registrations, much of which is confined to the age group 70 years and over in which there is a high preponderance of women. In England and Wales 53,354 registered blind persons (55 per cent of those shown in the table) were over 70 years old, as were 7,989 of the newly registered (71 per cent of those shown in the table). The equivalent figures in Scotland were 4,672 (47 per cent) and 791 (63 per cent). If these trends continue, an increasing proportion of the blind will in future also be aged. The present picture of the welfare services for the blind is described in paragraphs 510 to 526. Information on the staffing of the service is given in paragraphs 336 to 338.

(b) **The deaf and hard-of-hearing**

The deaf

276. Dr. Johnson described deafness as the most desperate of human calamities and those with personal knowledge and understanding of the effects of total deafness, whether from birth or later, might find it hard to improve on this description. It is difficult, too, for those with normal hearing to imagine a world with no bird song and no music—even no motor horns—or to conceive the frustration of the mother who cannot hear her baby cry, or the kettle boil. It is hard to understand that without language there can be no concepts, and thought itself is limited. Until it was realised that without fairly normal hearing there cannot be normal speech (since speech depends on an imitation of what has been heard) many of the so called 'deaf and dumb' were sometimes regarded as mentally defective. Only in comparatively recent years has the importance been recognised of early auditory training of deaf children to give their intelligence a chance to develop.

277. Current developments in the ascertainment and education of deaf children affect our inquiry in so far as these children may require help from social workers in childhood or adult life. We consider these developments further in paragraphs 290 to 291. In defining those for whom services are required under the National Assistance Act we have found it convenient to use the definitions suggested by the Ministry of Health and the Department of Health for Scotland when local authorities were invited to draw up schemes, namely

> " The *Deaf*—often described as the " deaf and dumb ". This class includes persons who are born deaf and also persons who lost their hearing so early in life that they have little or no recollection of sound and have to be educated in the same way as those who were born deaf. Few succeed in acquiring the use of normal speech. The great majority use only a manual sign language or a combination of signs and restricted speech in which the power of self-expression is limited and in any case varies considerably with the individual. Many are unable to read fluently and can do no more than gather the general substance of simple printed matter.
>
> The *Hard of Hearing* are those who have lost their hearing wholly or in part after acquiring ordinary speech and after being educated as hearing persons."[1]

We recognise however that recent developments in ascertainment and education are making a revision of these definitions desirable.

278. The origin of voluntary effort for the deaf and the development of special educational facilities for deaf children were noted briefly in paragraph 258. In 1930 increasing public interest in the care of the deaf led

[1] Ministry of Health Circular 32/51, page 7; Department of Health for Scotland Circular 14/1951, Appendix, page 26.

to an enquiry by the late Dr. A. Eichholz, C.B.E., formerly Chief Medical Inspector of the Board of Education. His report,[1] published in 1932, dealt exhaustively with the education of deaf children and with the conditions of the deaf in adult life.

279. Much of the interest in this study lies in the assessment of the needs of the adult deaf. Satisfactory employment was found to be a primary need, but lack of vocational training and suitable employment figured prominently among the underlying causes of unsatisfactory conditions. Other causes were mental defect or weakness, or behaviour difficulties described as character defects. In the latter category Dr. Eichholz recognised various degrees of maladjustment arising from the lack of means of communication, and the inability to adapt to ordinary social life. He assumed that some at least of those with severe temperamental difficulties would eventually find their way to mental hospitals, " to swell the list, disproportionately heavy already, of the insane deaf and dumb ".[2] Investigation at that date showed that 1 in 42 of an estimated deaf and dumb population of 35,000 were receiving institutional relief because of mental illness or infirmity. This high incidence rate (compared with a rate of 1 in 295 of the estimated general population) appeared to be related to the poor mental start of the deaf in childhood, and to

> " the burden of mental weakness among the deaf in connection with the temperamental life they are compelled to lead, struggling against the adverse circumstances of continued mental isolation and misunderstanding, and the wear and tear of temper which eventually saps mental health."[3]

Investigations also revealed a high proportion of the deaf and dumb in receipt of public assistance, especially institutional relief, as compared with the general population. It appeared that destitution fell with more than double the weight on the deaf than on hearing persons, and that the real weight fell upon those who were sick or mentally infirm, or in need of institutional care. The report gives a vivid description of the aged deaf whose entry into the workhouse

> " means confinement to mental solitude and isolation for the rest of their lives. Neither inmates nor staff can, as a rule, understand them or extend to them even the limited amenities of social life. Save for the occasional visit of a missioner to the deaf and dumb or of a chance relative they are cut off from contact with the human mind, and to many the friendly visit eagerly anticipated never comes."[3]

280. This picture of some of the effects of deafness has fortunately changed for the better, particularly in the educational field and in the ascertainment and treatment of deafness, but the incidence of mental illness and defect still remains significantly high. The National Institute for the Deaf, in giving evidence to the Royal Commission on the Law relating to Mental Illness and Mental Deficiency in 1954, drew attention to the figure of 5·5 per thousand mental hospital beds in the North of England occupied by deaf and dumb patients,[4] which agreed closely with the incidence of 5·2 per thousand deaf and dumb in mental hospital beds in the country as a whole. The National Institute referred also to the estimate of 0·5 per thousand deaf children in the total population and, taking this as a reasonable estimate

[1] *A Study of the Deaf in England and Wales*, 1930–1932, by Dr. A. Eichholz, C.B.E. H.M.S.O., 1932.
[2] Ibid., page 151.
[3] Ibid., page 114.
[4] For this purpose the National Institute for the Deaf defined the deaf and dumb as the born deaf and those who had become deaf very early in life.

for the incidence of deafness in the community, pointed out that the proportion of deaf persons in the mental hospital population was eleven times higher.

281. Dr. Eichholz's study was made immediately after the transfer of Poor Law functions, at a time when the authorities concerned were still engaged in reorganising the services. A number subsequently used their powers to make grants to the deaf missions and societies in their area, but it would be true to say that for the next twenty years or so their contribution to the welfare of the adult deaf was almost negligible, and the voluntary societies and missions continued to work alone in the field. The number of these organisations had grown by 1948 to about 80 in the country as a whole, but the areas covered were sometimes ill-defined, and some parts of the country even today lack any provision. The National Institute for the Deaf is mainly a co-ordinating body which also maintains homes and hostels for the deaf, and has a technical research department for the evaluation of hearing aids and other acoustic equipment. In England and Wales Regional Associations for the Deaf act as a link between the voluntary organisations and the National Institute, and such local authorities as contribute to the Associations. The Scottish Association for the Deaf undertakes similar functions in Scotland.

282. The voluntary societies and missions for the deaf were originally staffed by 'missioners', usually ordained clergy, following the original religious impulse on which the service was founded. As the work expanded into the employment field and to the provision of social and recreational facilities, lay officers also began to be employed. In the early years these officers and the missioners (apart from their theological training) learned the needs of the deaf 'on the job' under the supervision of experienced missioners. In 1929, a Joint Examination Board, subsequently known as the Deaf Welfare Examination Board[1], was established by the voluntary organisations concerned to select and examine candidates for the diploma or certificate of the Board; the former includes spiritual and social knowledge, the certificate relates to welfare work as distinct from religious ministration.

283. The National Assistance Act broke new ground in 1948 by enabling local authorities, if they so desired, to provide services for the deaf and hard-of-hearing, either directly or through agency agreements with voluntary organisations. In general, it was expected that the services required would follow the pattern of those already provided for the blind (other than provision for sheltered employment). The duties of welfare officers would also follow this basic pattern with the proviso that staff dealing with the deaf should be familiar with the manual language and methods of communication other than normal speech. Welfare officers for the purpose of this service should, unless otherwise prescribed, be

> " persons holding a diploma or certificate in social science or a similar qualification in social work of a comparable character, or persons as respects whom the council are satisfied that they enjoy a special aptitude for the work, possess a broad knowledge of the social services and some experience in the field of welfare, and have an understanding of the problems of deafness and the principles of deaf education."[2]

[1] Under the revised constitution, with effect from April 1957, the National Institute for the Deaf is responsible for the training of welfare workers. Responsibility for the selection and examination of candidates and for the qualifying award remains with the Board.

[2] Ministry of Health Circular 32/51, page 6.

284. In Scotland it was suggested that welfare officers should

> " have fluency in methods of communication with the deaf or dumb and such other qualifications as may be prescribed by the Secretary of State. Pending the making of regulations he shall hold a diploma or certificate in social science. In so far as the appointment of officers with such qualifications may be impracticable for the time being, welfare officers may be appointed from among persons who in the opinion of the Council show a special aptitude for the work and have already a broad knowledge of the social services and some experience in the field of welfare."[1]

285. In 1951, authorities who wished to exercise their powers were invited to submit schemes. By 31st December, 1957, 144 schemes from authorities in England (104), Wales (7) and Scotland (33) had been submitted and approved. Once a scheme has been approved, the authority must keep a register of those who apply for assistance or who are assisted. Registration is voluntary, providing no financial benefit, so that until the service becomes known, or is at least partially developed, there is not much incentive to register. The present registers are known to be incomplete, particularly as some authorities have not registered children. The latest figures available for England and Wales show that 2,213 children under 16 and 15,613 adults, of whom 2,251 were over 65, were registered at 31st December, 1957. On the same date 742 men and 1,022 women were in residential care (of whom 314 were in voluntary homes), but the two sets of figures are not mutually exclusive. Statistics about deaf children have been available in the education services for many years. The latest figures show that 3,748 deaf children are receiving special educational treatment at the present time. Information on the staffing of this service is given in paragraph 339. The present picture is described in paragraphs 527 to 533.

The hard-of-hearing

286. Unlike the deaf many of the hard-of-hearing grew up with normal hearing and are more able to maintain contact with the hearing world, particularly since the provision of hearing aids through the National Health Service. The demand for these aids in the early days of the service showed how many people suffered from this handicap. In advising authorities on the preparation of schemes for the hard-of-hearing under the National Assistance Act, Ministers suggested that the main need would be assistance in conserving and making the best use of residual hearing, advice and instruction in the proper use of hearing aids and in lip-reading, and facilities for social intercourse.[2]

287. The British Association of the Hard-of-Hearing is the national voluntary organisation concerned with the hard-of-hearing. It promotes the interests of its members and co-operates with central and local authorities. It also encourages self-help, the practice of lip-reading and the use of hearing aids, and advises on employment and other difficulties. The Association offers affiliation to existing voluntary centres ; it helps to promote new centres and clubs for social and cultural activities. It was estimated that there were about 140 of these centres in 1951, and the number has probably grown since.

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[1] Department of Health for Scotland Circular 14/1951, Appendix, page 36.
[2] Ministry of Health Circular 32/51, pages 9–10; Department of Health for Scotland Circular 14/1951, Appendix, page 29.

288. In England and Wales 961 children and 11,404 adults (of whom 4,873 were aged 65 and over) were registered on 31st December, 1957, as hard-of-hearing. Figures provided by the Ministry of Education showed that 1,619 partially deaf children were receiving special education.

289 These figures, and those for the deaf given in paragraph 285, may be compared with the estimates made by the Central Office of Information Social Survey[1] from a series of classified random samples of the population over the age of 16 years. The number of deaf (those deaf from birth or from such an early date that speech was never learned by normal means) was estimated at 15,000. This is slightly less than the number of persons now registered as deaf, a discrepancy which may be due to difficulties in distinguishing precisely the more extreme cases of hard-of-hearing from true deafness. The number of hard-of-hearing was estimated at 1,750,000 distributed in four categories as below:

People unable to hear speech, but who become so after learning speech by normal means	30,000
Deaf to all natural speech without an aid	70,000
Able to hear loudly spoken speech	790,000
Able to hear ordinary speech at close range	860,000

It is clear that even among the first two categories of those totally unable to hear natural speech, or able to hear it only with a hearing aid, the proportion registered with local authorities is small.

Ascertainment and treatment of defective hearing

290. Recent developments in the ascertainment and treatment of defective hearing and in modern techniques and hearing aids make it likely that many children who would previously have been classified as deaf will in future acquire understanding and use of speech. Although it is no doubt too early for major developments to be forecast with any certainty we have acquainted ourselves with the possibilities because of their bearing on the services now being developed by local authorities under the National Assistance Act.

291. The experimental work of Sir Alexander and Lady Ewing and Miss Edith Whetnall, F.R.C.S., has resulted in a greater understanding of the causes and effects of deafness in young children. The importance is now generally accepted of early recognition of the disability, in order that children with serious hearing defects may be encouraged by auditory training and the use of hearing aids to make use of such hearing as may be left to them. The aim is to attain auditory discrimination during the first two or three years of life, a period which is now known to be crucial for the acquisition of speech. There has also been a gradual lowering of the age at which the special education of deaf children can be started to bring it more closely in line with the age range within which human beings are normally capable of learning to speak. In order that children with hearing defects may be referred in good time to hospital or local authority clinics, an increasing number of school nurses and health visitors are being trained in the use of screening tests for hearing in young children and babies. They are also trained to give advice and guidance to parents, who may have detected the handicap, and later to teach them to help the small child to speak and to

[1] The Prevalence of Deafness in the Population of England, Scotland and Wales. *Central Office of Information Social Survey (revised December, 1949).*

use a hearing aid. The Ministry of Education considers it unlikely that many deaf children of compulsory school age can now remain unknown to local education authorities for more than a short period.

(c) **The general classes of handicapped persons**

292. We referred briefly in paragraph 262 to modern methods of medical treatment and the appliances and gadgets of various kinds which have done much to improve and increase physical mobility among the physically handicapped. Coming to terms with a disability, however, is still something which each must, in the end, achieve for himself. The services for the generally handicapped were designed to assist in this process where necessary, and to ease related problems and difficulties, especially when the degree of disability is such that an independent life is not possible.

293. The care of physically handicapped children was originally part of the work of the 19th century voluntary organisations for the education and general welfare of destitute and homeless children. A few, of which the Shaftesbury Society is the best known, developed a special interest in handicapped children. Later the Invalid Children's Aid Association, working mainly in London and the home counties, pioneered services for such children in their own homes. The Association was one of the first to realize the importance of considering the mental (in the broad sense) as well as the physical health of children and the needs of the handicapped child in, rather than apart from, his family, and consequently to base its work on family casework principles.

294. In other parts of the country local or county associations for the crippled or physically handicapped, and organisations similar to the Invalid Children's Aid Association, enlisted local help and interest for both children and adults. Many of these schemes were started to procure or provide orthopaedic treatment, education and after-care, and vocational training and employment were on the whole later developments. Some provide a range of services including home worker schemes and occupational therapy. The formation and development of county associations is encouraged and financially assisted by the Central Council for the Care of Cripples, which acts as a co-ordinating body and offers affiliation to the 30 or so associations. Since the war, the civilian welfare department of the British Red Cross Society has also developed services in this sphere, mainly the provision of gadgets and aids to living, or the teaching of handicrafts. In some areas local branches, like the county associations, act as agents for the local authority. The National Association for the Paralysed, founded in 1948, provides an advisory service on matters essential to the well-being of the paralysed, and co-operates with statutory and voluntary bodies in individual cases. A number of voluntary organisations concerned with specific disabilities have also been established in recent years.

295. Few voluntary organisations for the handicapped employ trained social workers, and no planned in-service training has developed. The Senior Officers of the County Associations' Committee of the Central Council for the Care of Cripples suggested in evidence that so many different skills and sciences were required that it would be difficult to stress any one type of training as more important than another. This in itself seems to imply that training is necessary. Generally the value and importance of craft work and handicrafts

have been recognised by the appointment of trained craft instructors, or occasionally occupational therapists. The Central Council for the Care of Cripples organises study groups and conferences for workers in this field from time to time.

296. There is no statutory definition of the term 'substantially and permanently handicapped', other than that persons may be thus handicapped "by illness, injury, or congenital deformity or such other disabilities as may be prescribed by the Minister".[1] No specific disabilities have so far been prescribed, as it has not been considered practicable to define more precisely the persons who may be dealt with. The classifications used in the registers of the general classes of handicapped persons include defects or disabilities acquired before, or at, birth or during childhood, permanent disability resulting from accident or disease, and the chronic or progressive physical and nervous disorders.

297. In 1951 local authorities were invited to submit schemes for this service as well as for the deaf and hard-of-hearing. By 31st March, 1957, 76 per cent of authorities (111 in England, 8 in Wales and 34 in Scotland) had had their schemes approved. As noted in paragraph 247, 30 per cent of authorities have placed responsibility for these services on the health committee.

298. As with the deaf and hard-of-hearing, registration is voluntary. The latest figures show that in England and Wales, 5,008 children and 59,692 adults (of whom 11,260 were aged 65 and over) were registered under the schemes on 31st December, 1957. These figures do not give any real indication of the numbers of persons who are handicapped within the meaning of the Act, as not all authorities have approved schemes. There is also considerable variation in the way in which registration has been carried out. In some areas the register is thought to be fairly complete or even inflated. In others, there has been little or no publicity because of lack of staff, or registration has been on a selective basis. The time taken to build up a register is variable; two county boroughs of comparable size and type, for example, have registration figures of 22 and 232 respectively; one fairly large county administering its own service has registered 35 handicapped persons, while the voluntary association covering the county area has 994 live cases on its books. The existence of an approved scheme does not, therefore, imply either that registration is complete or that an effective service is being given. Some of this uneven development is undoubtedly caused by financial restrictions, but comparison with more fully developed services suggests it may also be due to lack of staff with the requisite training or experience. It seems clear that at present the numbers on the registers do not indicate the size of the problem, but simply reflect the extent and type of service provided. They are always liable to fluctuate, and people are more likely to apply for registration when they have some knowledge of the benefits available. The experience of those authorities whose services have been effectively in operation for some years shows that these are undoubtedly meeting a previously unsuspected need, and that as they expand new needs are revealed.

299. The special welfare needs of those suffering from epilepsy and from cerebral palsy, were considered by the Advisory Councils on the Welfare of

[1] National Assistance Act, 1948, Section 29 (1).

Handicapped Persons in England and Wales and in Scotland.[1] In England and Wales the Council drew attention to the fact that persons suffering from progressive nervous disorders such as Parkinson's disease or disseminated sclerosis often required similar services to those suffering from cerebral palsy. It also noted the need for special residential care for the younger age groups unable to live at home. Both reports stressed the importance of complete co-ordination of effort and team-work by all concerned. The report on epileptics referred to the value of extensive propaganda on the nature of epilepsy in overcoming current prejudices and misunderstanding, and to the importance of closer co-operation between the local authority departments concerned and the statutory and voluntary epileptic colonies. The medical care of epileptics in England and Wales has since been considered by a Sub-Committee on the Standing Medical Advisory Committee of the Central Health Services Council which expressed the hope that the domiciliary services provided by health and welfare authorities would be expanded as quickly as possible.[2]

300. The Ministry of Health Advisory Council's report on spastics stressed the need for the utmost care in the intelligence testing of children to avoid certification as mentally defective, and for comprehensive care and welfare services. Authorities were asked to consider the possibility of establishing joint homes for the more severely handicapped, including those unsatisfactorily housed in residential accommodation under the National Assistance Act.

301. Attention has also been paid in recent years to certain other groups of handicapped persons where special considerations apply in medical care and treatment, and in education and employment. These are mainly the various degrees of paralysis or muscular degeneration, progressive nervous diseases and the physical disabilities resulting from severe haemophilia. Recently also the special problems of certain age groups have been more widely appreciated : the care of severely handicapped young children, for example, or the difficulties which face young disabled adults in obtaining and keeping satisfactory employment. The Carnegie United Kingdom Trust has recently undertaken a survey of the provision for young handicapped children at home which may throw further light on some of these problems.

302. The duties and qualifications of local authority welfare officers in these services as envisaged in departmental circulars[3] are broadly similar to those of deaf welfare officers outlined in paragraphs 283 and 284. The circulars emphasise the importance of experience in and special aptitude for work with handicapped persons. In 1953, the Ministry of Health Advisory Council for the Welfare of Handicapped Persons appointed a Committee to consider the training and qualifications appropriate to staff in the services covered by Section 29 of the Act, that is for the blind, deaf, and general classes of handicapped persons. The Committee recommended a provisional training scheme for two types of officer, namely, welfare officers undertaking the day-to-day work in the field, referred to as visiting officers, and new recruits to the service without previous social work training. In 1954, the Advisory

[1] Appendix to Ministry of Health Circular 26/53; Department of Health for Scotland Circular 103/1952.

[2] H.M.S.O. 1956, paragraph 74.

[3] Ministry of Health Circular 32/51, pages 14–15; Department of Health for Scotland Circular 14/1951, Appendix, pages 11–12.

Council concurred in the view expressed by the local authority associations that the stage had now been reached when an investigation into the whole field of training, qualification and employment of social workers in the relevant parts of the health and welfare services was desirable, and there the matter rested until we were appointed in the following year. We have studied the Advisory Council memorandum and the training proposals carefully and refer to them further in paragraph 856.

303. The services for the general classes of the handicapped, as for the deaf, are still at an early stage. The Piercy Committee,[1] in reviewing the progress made so far, concluded that only the fringes had been touched and there was no doubt of the need for fuller and better provision. They recognised that the kind of services required by handicapped persons would vary according to the nature of the handicap and the degree of personal adjustment achieved, and drew a distinction between the disabled in employment and those unable to work, suggesting that the responsibilities of local authorities in the welfare services embraced the social needs of both categories. They also suggested that the provision of occupational and social centres should be one of the main objectives in meeting the needs of disabled persons other than by employment. Other recommendations affecting local authority services included the need for short-stay hostels and permanent homes for the disabled leaving hospital or in need of permanent care. The Committee noted the financial implications of establishing these new services and considered that the general pressure on local authorities for economy in services and expenditure must inevitably have retarded development. They believed that more would have been done if the services had attracted grant aid from central funds. It seemed to them anomalous, for example, that an occupational therapy department in a hospital should be entirely financed from Exchequer funds, whereas an occupation service provided by a welfare department at a social or craft centre attracted no grant whatever. They recommended accordingly that local authorities should be grant aided by the Exchequer in their expenditure on services provided under Section 29 of the National Assistance Act, without distinction between the type of disabled person or of service concerned. Under the Local Government Act, 1958, and the Local Government and Miscellaneous Financial Provisions (Scotland) Act, 1958, provision is made for expenditure on the development of the services for the handicapped under the National Assistance Act to be taken into consideration in assessing the amount of the general grant. In outlining these proposals to local authorities the Minister of Health[2] drew attention to other recommendations made by the Piercy Committee and asked the relatively small number of authorities who had not yet submitted schemes to reconsider their policy in this respect.

304. The Piercy Committee were asked, in their terms of reference, to bear in mind the need for the utmost economy in the Government's financial contribution, and the only major item of new expenditure recommended was the Exchequer grant for the welfare services. The Committee were at pains to point out that it should not be assumed too readily that more effective services can be brought about solely, or even mainly, by increased expenditure ; and that the best work in the rehabilitation field relies on the capacity to

[1] Cmd. 9883.
[2] Ministry of Health Circular 16/58.

inspire self-help among the disabled, the intelligent use of available materials, and the personal enthusiasm of those engaged in the service. We would subscribe to the view that increased effectiveness does not depend only on increased expenditure, and that the capacity for self-help among the disabled, and the resourceful and intelligent use of available materials, are essential, though it may require skill to mobilise self-help. We would add, however, that in the light of the requirements of the service as so far revealed responsible local authority officers also require appropriate training if the services are to fulfil the purpose for which they were designed.

305. The staffing of these services is described in paragraphs 340 to 341 ; the present position is outlined in paragraphs 537 to 549.

CONCLUSIONS

306. So far we have described briefly and factually the historical development of the various services down to the present day. It now remains to indicate certain broad trends which seem to be discernible in these services, in spite of their varied development, usually in isolation from each other.

307. During the 150 years or so in which these voluntary and public services have been emerging in the form in which we know them today, attitudes towards, and knowledge about, the cause and cure of social evils have undergone radical changes. In broad terms it would be true to say that in past centuries physical handicaps and mental defect were regarded as inevitable and incurable. Mental illness was an inherited blemish or else a terrifying visitation which still conjured up witches and possession by devils, and restraints and firm control were essential. On the other hand, unmarried motherhood, thriftlessness and squalor were due to moral laxity, failure of the will, and general improvidence.

308. Today the picture has changed, and is changing in several respects. The number of blind babies has fallen in a spectacular way with the eradication of ophthalmia neonatorum. Blindness is becoming mainly a disability of old age in those who have often enjoyed sight for their three score years and ten. The number of babies born deaf is likely to decrease as more becomes known about the causes of congenital abnormalities. The number of children born with crippling defects has not altered appreciably in recent years but medical science has made considerable progress in the treatment of certain congenital defects, and also in the treatment and training of children suffering from cerebral palsy. At the same time, poliomyelitis is likely to be brought under control. The result is that a greater proportion of those who become blind, deafened, crippled, or otherwise physically handicapped in later life, will while they were young have run and laughed, sung and shouted, seen the changing scenes of life, heard its many sounds and been, so far as the freedom of their bodies was concerned, no different from their peers. From this group of ordinary children a few will become the 'young chronic sick'; industrial injury, road accidents and accidents in the home and elsewhere will maim more of the others for life. Then, as time goes on, disease or degenerative processes will lead to diabetes, disseminated sclerosis, arthritis and other crippling conditions, to increasing deafness, blindness, and finally to the totality of ageing. And this toll of defect and injury will happen to those who once were whole, who once

enjoyed sight and sound and movement. All that can be done for them—and it may be a good deal—is to mitigate the condition itself, to help them and their families to face the shock and the major adjustments which may sometimes be needed, to supply contrivances in the home and outside it, together with such employment and interest as are possible.

309. The development of care for old people has on the whole been in the reverse order from that for the handicapped, that is to say, attempts to meet their social and personal needs preceded efforts to provide semi-sheltered employment for them. The first concern was to rescue them from the Poor Law by almshouses, and later by old age pensions, and only in the early 1940's did they come to be regarded as a separate category of persons about whose welfare various voluntary organisations began to be active.

310. Some of the more unenlightened attitudes towards the mentally ill and defective in the nineteenth century present a sadly different picture from those manifested to the physically handicapped or the old. The fact that physical handicap arouses that mixture of emotions called compassion, whereas mental disorder may call forth fear in its more primitive forms, may account for some of the differences in public attitude and social concern. If the one shows man's humanity to man, the other is a dark instance of man's inhumanity to man. Segregation and custodial care were the characteristics of a period which has saddled us with vast and prison like mental hospitals and mental deficiency institutions. Nevertheless there were pioneers also in this field even before recent advances in psychiatry began to cast light on the nature of mental disorder and the possibilities of treatment.

311. At the present day it seems evident that mental disorder is making greater claims on the medical and social services, but this does not necessarily mean an increase in its incidence. The greater awareness of the nature of mental disturbance, which may appear as excessive anxiety, depression or fears rather than as serious mental illness, and a growing appreciation of the possibilities of treatment have made many more mentally ill persons willing to apply for help. These minor disturbances might previously have been overlooked, leaving the individual alone to endure his suffering, or have called forth blame or admonition.

312. Modern views favour early treatment, the avoidance of hospitalisation where possible, the development of services for the mentally ill which enable them to go on living in the community, and occupational therapy. This necessarily involves a large element of social work. The therapeutic value of suitable employment is recognised, as are the benefits of social clubs and hostels. An attempt is now being made to approximate conditions of treatment for the mentally ill with those for the physically ill, and with the consequent removal of any unnecessary compulsion more responsibility will fall on the local community. Perhaps most important of all are efforts to make it possible for the family to care for its physically or mentally handicapped members. Many of these modern trends also apply to the treatment of mental defectives by the provision of suitable training and employment, occupation and group activities and, where necessary, residential care. The tendency is now to provide for them in the community and accordingly there will be increasing demands on the social services to enable all but the lowest grades to lead satisfactory lives in the community and to make full use of their abilities, limited though these may be.

313. The swing away from residential care or treatment of all kinds so characteristic of the post-war period is no doubt partly due to shortage of staff and shortage of building resources, but also to a new emphasis on keeping handicapped people (using that term in its broadest sense) part of the community rather than segregating them in institutional care. At various points in the following chapters we discuss this tendency so far as the rapid turnover of hospital beds is concerned, together with increased home care for the tuberculous. In brief, the effect is that some of the services which a hospital provides must be brought to the home, partly for treatment purposes and partly to lessen the strain on relatives. The acuteness and duration of the illness naturally affects the needs which must be met. And there comes a point at which the chronic sick shade into the general classes of handicapped persons.

314. The other groups within our terms of reference, unmarried mothers and their babies, 'problem' families and the temporarily homeless present rather different features. Except for those who are homeless on account of fire or other unforeseen circumstances, there is a considerable proportion of social deviants in all three of these groups. In them will also be found a certain number of people who are feeble-minded, psychopathic, emotionally immature or unbalanced. They thus present a psycho-social problem or series of problems in an acute form. Not the least of these problems is, as with the mentally ill, the attitudes of rejection, condemnation and authoritative direction which they arouse in their fellow citizens. But here, too, condemnation based upon older assumptions about rational behaviour is being altered by scientific inquiry. Instead of saying "they ought not to behave like that" we are beginning to ask "why do they behave like that?". The step from disapproval or fatalistic acceptance to an acknowledgment that there must be causation and to an attempt to discover its nature is always the initial requirement for any advance, whether in medicine or social reform. This does not preclude empirical discovery of methods of treatment which mitigate or cure, but these by their very success pose the question of why they succeeded.

315. It is not always easy to know to which science to address questions about cause and cure, particularly when the multiple causation of social deviance is becoming clearer. For example, some of the questions about unmarried mothers and 'problem' families were first addressed to genetics. They are now being posed to psychology, psychiatry and sociology. That is to say, personality development and the effect of social influences on individual behaviour seem now to be the places to look for some of the clues. The beginnings of scientific inquiry in this field suggest that there may be causative factors at work both as precise and as complex as in physical disability. At the same time, some behaviour which was previously explained wholly in moral terms is now beginning to be explained in scientific terms, while some illness and disability which were previously regarded solely as 'acts of God' are now seen, if not as 'willed', at least as a reaction of the whole person to life's demands, and in that sense 'purposive'. Moreover, the reactions of people and their families to disablement and handicap are themselves discovered to be to some extent predictable and to lend themselves to remedial action in psychological and social terms. At the present day the frequently devastating consequences for children of

illegitimacy and the chequered childhood that often accompanies it, coupled with the conflict of emotions to which the mother may be subject, have heightened concern for unmarried mothers and their children. This is accompanied by a feeling that it is not desirable to single out unmarried mothers for treatment as a distinct group to any greater extent than circumstances may make inevitable.

316. 'Problem' families are as yet unencumbered by history. They are a comparatively new phenomenon, so far as social awareness is concerned. They were not apparent in the general morass of slum life where some degree of child neglect or failure in social upbringing was often caused by large families, combined with slum housing and life below the poverty line. Now, however, the family which fails to raise its standards as these improve all round, stands out as an object of social concern. Numerous descriptions of these families have been given since the days before and during the war when certain medical officers of health and public assistance officials began to be concerned about them, and when the then Pacifist Service Units started to work with them to try to discover the causes of their squalor and to raise them from it. In contrast to the welter of moral condemnation of such families a certain amount of research and inquiry into causation has been undertaken. The earlier descriptive analyses are now giving way to 'action' research through carefully recorded long-term work with a small number of families. The results so far suggest, as might be imagined, that they are only an entity in that they represent a problem to society. The range of families grouped under this heading is a wide one, and the results of inquiry do not go much beyond demonstrating the heavy concentration of feeble-mindedness, emotional immaturity, inadequate personality development and lack of sense of social obligation in such families, compared with the general run of the population. This is tantamount to saying that many of them have the physical development of adults but are otherwise very much like severely deprived children. So far as society is concerned, it is dirt, squalor, malnutrition, inadequacies in child rearing, illegitimacy, delinquency, and failure to pay the rent which attract attention. At the same time, the house which is noticeably unswept and ungarnished may yet sometimes provide a home and "the vitamins of mental health". So far, public attention has not been directed to the house which is all too well swept and garnished but which is not a home and where the children may suffer from emotional malnutrition and neglect.

317. The last group within our terms of reference, the homeless in temporary accommodation, are homeless for varied reasons but they include a certain number evicted for non-payment of rent, who may be akin to 'problem' families. It is only quite recently that the homeless have begun to attract public concern. This is a group whose needs and problems were perhaps masked, or at least not faced, in the days when many more people were destitute, and when to separate children from their not very adequate parents was often regarded as a benefit rather than a calamity. Now, however, the situation is beginning to change, and it seems as though the problem of the homeless, why they are homeless, and what can and should be done about it is beginning to arouse the same interest and concern as the other groups within our terms of reference. Attempts are being made to prevent families from becoming homeless, to set them on their feet

again, and to give them the personal support they need for a short or long period in re-discovering and retaining their place in society. It is possible that some of these families are substantially and permanently handicapped so far as ability to function as an independent social unit is concerned but the implications of this possibility have not as yet been faced.

Chapter 2

THE EXISTING STAFFING OF THE SERVICES

318. This chapter, which is based mainly on the replies to the questionnaire sent to local authorities, contains information on the existing staffing of the services within our terms of reference. It is divided into three sections: staffing statistics, salaries, and conditions of work.

STAFFING STATISTICS

319. Local authorities were asked in Part II of the questionnaire (see Appendix B) to provide details of certain staff in post on 1st May, 1956. We did not consider it advisable to attempt any precise definition of 'social work' or 'social worker', but preferred to know which officers local authorities themselves regarded as social workers within the general definition which accompanied the questionnaire, and which was supplemented by more specific guidance on particular groups of officers. Local authorities were asked to include administrative officers whose duties contained a social work element, particularly those responsible for the administration of the welfare services, either directly to the council or for day-to-day administration, or for both. Proformas of two tables were provided for use in preparing replies: the first to show which officers were employed as social workers in each of the services within the scope of our inquiry and the second to provide detailed information relating to individual officers. A distinction was drawn between officers employed primarily as social workers and officers with a social work function subsidiary to their main employment. This was done to ensure, so far as possible, that the replies included all officers with whom we might be concerned.

320. It was not to be expected that every local authority would take the same view as to the types of officer to be included in replies. Certain kinds of staff (for example, staff of residential accommodation and occupational therapists) were included by some authorities and excluded by others. On the whole, however, replies showed a fair measure of agreement throughout the country. Information was received relating to the following main groups:—

(i) Officers responsible to the council for the welfare services, or for the day-to-day administration of these services or for both, including chief welfare officers, medical officers of health, and county or town clerks.

(ii) Officers employed as welfare officers, or as mental welfare officers,[1] or combining the functions of welfare officers and mental welfare

[1] See paragraph 219 for use of this term.

officers, but without the chief officer responsibilities of the previous group.

(iii) Administrative officers with some social work functions, many of whom were also visiting officers.

(iv) Workers with the blind.

(v) Workers with the deaf.

(vi) Workers with the general classes of handicapped persons (other than welfare officers) including occupational therapists and craft instructors.

(vii) Psychiatric social workers, and other social workers employed in community care.[1]

(viii) Almoners registered with the Institute of Almoners, and other social workers in the after-care services.

(ix) Workers with families, including 'problem' families.

(x) Home help organisers and deputies.

(xi) Staff of residential accommodation.

(xii) Visitors to residential accommodation.

(xiii) Occupation centre staff.

(xiv) Nursing staff, including health visitors.

(xv) A small number of other staff who could not be grouped under these headings.

321. General staffing tables in Appendix E show :—

(*a*) Numbers of officers of various designations (Table 40).

(*b*) Ages of officers (Table 41).

(*c*) Qualifications of welfare officers, mental welfare officers and administrative officers with some social work functions (Table 42).

(*d*) Employment of men and women with special reference to part-time employment of married women (Table 43).

(*e*) Occupations of officers holding social science degrees, diplomas or certificates (excluding professionally trained social workers) (Table 44).

Detailed consideration is given to these various groups in the following paragraphs.

Chief welfare officers[2] and others responsible for the administration of the welfare services

322. The responsibility of particular officers for the administration of the welfare services in relation to committee structure is shown in Appendix D. It is sufficient here to say that 177 chief welfare officers (with 69 deputy chief welfare officers), 68 medical officers of health, and 14 county and town clerks, were included in replies as responsible either to the council, or for day-to-day administration, or in both of these ways. The post of chief welfare officer or deputy chief welfare officer provides an avenue of promotion

[1] These other social workers are referred to in Whitley Council circulars as 'other social workers employed in psychiatric departments and clinics'—a term introduced to replace 'unqualified psychiatric social workers'. This term is not appropriate to the officers with whom we are concerned, and we therefore refer to them throughout this Report as 'other social workers employed in community care'.

[2] In this chapter, as elsewhere in this Report, the term 'chief welfare officer' is used for officers variously designated as chief welfare officer, county welfare officer, director of welfare services, etc.

for welfare officers, so that detailed information is relevant to recruitment to the welfare services. This does not apply to medical officers of health or to county or town clerks, whom we have not considered further.

323. As shown in Table 3 it was the almost universal practice in Scotland for officers responsible for administering the welfare services to act also as authorised officers. In England and Wales this combination of functions was less common, but over 50 per cent of welfare officers with day-to-day administrative responsibility also acted as duly authorised officers. There were few deputy chief welfare officers in Wales and Scotland, but 29 in English counties and 35 in English county boroughs.

324. Of officers in this group, 30 were over 60 years of age, and 78 between the ages of 50 and 60. The group included six women officers, four with responsibility to the council (one Scottish county, one Scottish large burgh and two English county boroughs), one with responsibility for day-to-day administration and one as deputy chief welfare officer (two English county boroughs).

325. There is no recognised qualification for the post of chief welfare officer other than considerable administrative and local government experience: over 40 per cent of all chief welfare officers and their deputies had no qualifications other than these. About 33 per cent of the officers in this group held either the relieving officer's certificate or the Scottish poor law diploma; the diploma in public administration was held by 9 per cent. Five per cent held a social science certificate or diploma, usually obtained by part-time university study. More detailed information is given in Table 42.

Welfare officers and mental welfare officers

326. District or area welfare officers and mental welfare officers were considered by most authorities to be primarily employed as social workers. Replies to the questionnaire showed that 95 per cent of welfare officers and 97 per cent of mental welfare officers had visiting duties, often in combination with administrative functions.

Combination of functions

327. More than 50 per cent of welfare officers acted also as mental welfare officers with mental health or mental deficiency duties. It is convenient, therefore, to consider welfare officers and mental welfare officers (including duly authorised and authorised officers) under a single heading in the first place. Taken together, these officers numbered 1,619 and comprised over one-third of all those covered in the tables. Their functions were combined in a variety of ways which may be grouped under three broad headings, with two further groupings for assistants, as below:—

(*a*) 349 welfare officers who did not act also as mental welfare officers.
(*b*) 428 welfare officers who acted also as mental welfare officers.
(*c*) 625 mental welfare officers who did not act also as welfare officers.
(*d*) 192 assistants with welfare duties under the National Assistance Act, 1948 (assistants to (*a*) and (*b*) above).
(*e*) 25 assistants without welfare duties (assistants to (*c*) above).

The number of officers in each of these groups employed by county councils, county borough councils, and by councils of large burghs in Scotland is shown in Table 4.

Table 3: Welfare officers responsible for the administration of the welfare services

Officer		All 3 countries			England			Wales			Scotland		
		Total	Counties	County boroughs and large burghs	Total	Counties	County boroughs	Total	Counties	County boroughs	Total	Counties	Large burghs
(*a*) Responsible to the council and for day-to-day administration.	Also acting as duly authorised officer	23	11	12	2	1	1	—	—	—	21	10	11
	Not acting as duly authorised officer	99	43	56	87	35	52	9	7	2	3	1	2
(*b*) Responsible for day-to-day administration.	Also acting as duly authorised officer	39	20	19	19	7	12	4	3	1	16	10	6
	Not acting as duly authorised officer	16	5	11	14	3	11	2	2	—	—	—	—
(*c*) Deputy to either of above ...	... ...	69	33	36	64	29	35	2	2	—	3	2	1
Total number of officers		246	112	134	186	75	111	17	14	3	43	23	20

Table 4: Welfare officers and mental welfare officers: numbers employed by local authorities in England and Wales, and in Scotland

	All 3 countries			England			Wales			Scotland		
	Total	Counties	County boroughs and large burghs	Total	Counties	County boroughs	Total	Counties	County boroughs	Total	Counties	Large burghs
(*a*) Welfare officers ...	349	156	193	319	147	172	12	9	3	18	—	18
(*b*) Welfare officers also acting as mental welfare officers ...	428	391	37	249	229	20	44	44	—	135	118	17
(*c*) Mental welfare officers	625	318	307	597	303	294	23	15	8	5	—	5
(*d*) Assistants with welfare duties	192	118	74	143	91	52	4	3	1	45	24	21
(*e*) Assistants without welfare duties	25	19	6	23	19	4	—	—	—	2	—	2
Total	1,619	1,002	617	1,331	789	542	83	71	12	205	142	63

328. These figures confirm what a number of our witnesses told us, and what we ourselves saw on our visits, about the differing practices as regards combination of functions in England, Scotland and Wales, and in the country as compared with the town. A combination of welfare and mental health duties is more frequent in Scotland than in England or Wales; and in counties than in county boroughs or large burghs. This combination of duties is further considered in Chapter 6, in relation to the 'general purpose social worker' in our terms of reference. Besides undertaking combined duties under the National Assistance Act and in the mental health service, 96 of the 118 welfare officers employed in Scottish counties were also district clerks under arrangements found only in Scotland and described more fully in paragraph 410.

329. Six hundred and twenty-five officers worked entirely within the mental health services. Among these were 46 (7 per cent of the total) senior mental health or mental deficiency officers, of whom 44 were in England and 2 in Scotland. These posts carried a higher rate of salary, and thus provided an avenue of promotion for mental welfare officers. Table 5 shows the distribution of the remaining 579 posts and the extent to which statutory duties as duly authorised or authorised officers were combined with, or separated from, other duties within the mental health services. The great majority (77 per cent) of duly authorised officers also undertook other duties: officers acting solely as duly authorised officer were principally employed by councils of large county boroughs, and more than half of those employed by county councils were in London.

Age distribution, and employment of women

330. The number of men and women employed as welfare officers, mental welfare officers and assistants, and their age distribution is shown in Table 6. The proportion of women (most of whom were single) among welfare officers was small, but not negligible, being 16 per cent of those without mental health duties (Table 6 (*a*)) and 5 per cent of those with combined duties (Table 6 (*b*)). In contrast, the proportion of women among mental welfare officers (Table 6 (*c*)) was high (41 per cent), though it varied greatly according to the range of functions in the three groups distinguished in Table 5. In the first group, with a range of functions, women held 22 per cent of the 289 posts; in the second group, which acted only as duly authorised officers, women held 4·5 per cent of the 89 posts; and in the third group, undertaking other duties in the mental health services only, women held 88 per cent of the 201 posts. These figures alone do not fully state the extent to which women are employed as duly authorised officers. Including welfare officers and chief welfare officers, the total number of officers with duties as duly authorised and authorised officers was 858, of whom 10 per cent were women. Women also held 10 (22 per cent) of the 46 senior posts in the mental health services referred to above.

331. The information on the age of officers, particularly of men, pointedly confirmed what we had been told in evidence of the high proportion of welfare officers likely to retire in the next few years. Nearly 20 per cent of welfare officers were over the age of 60, and nearly 45 per cent over the age of 50. Even in the ranks of assistants, 6 per cent of the men were over the age of 60 years and 20 per cent over the age of 50 years. The high

Table 5: Range of duties of mental welfare officers without welfare duties

Range of duties	Numbers of officers											
	All 3 countries			England			Wales			Scotland		
	Total	Counties	County boroughs and large burghs	Total	Counties	County boroughs	Total	Counties	County boroughs	Total	Counties	Large burghs
Combining duties as duly authorised officer or authorised officer with other duties	289	145	144	289	145	144	—	—	—	—	—	—
Acting only as duly authorised officer	89	29	60	79	24	55	10	5	5	—	—	—
Not acting as duly authorised officer or authorised officer: other duties only	201	117	84	185	107	78	13	10	3	3	—	3
Total	579	291	288	553	276	277	23	15	8	3	—	3

Table 6: Numbers of men and women employed as welfare officers and mental welfare officers, with the percentage in given age ranges

Main groups of functions	Numbers of officers		Percentage of officers of each sex in age range				
	Of known sex	Of known age	Under 30 years	30/39 years	40/49 years	50/59 years	60 years and over
(*a*) Welfare officers	Men 294	286	5·6	23·7	27·3	24·2	19·2
	Women 55	55	5·5	38·2	32·7	21·8	1·8
(*b*) Welfare officers also acting as mental welfare officers.	Men 405	389	2·8	16·7	32·8	29·7	18·0
	Women 23	19	10·5	15·8	31·6	31·6	10·5
(*c*) Mental welfare officers ...	Men 370	370	3·0	20·8	36·0	26·2	14·0
	Women 255	253	13·0	16·6	43·1	19·8	7·5
(*d*) Assistants with welfare duties	Men 159	155	20·0	33·5	22·6	18·1	5·8
	Women 33	31	19·4	29·0	32·3	19·3	—
(*e*) Assistants without welfare duties	Men 21	21	28·5	47·6	14·3	4·8	4·8
	Women 4	4	25·0	25·0	25·0	25·0	—

proportion of officers in the upper age ranges shows the need for improved recruitment to replace experienced officers leaving the service. The responsibility which attaches to these posts was reflected in the fact that only 5 were under the age of 21—all of them assistants with welfare duties. The age distribution of mental welfare officers did not differ greatly, and similar conclusions may be drawn about the need for replacement of the most experienced officers in the next few years.

Qualifications

332. There is at present no recognised qualification for welfare officers. Since 1948 appointments have generally been made in the light of knowledge, experience (especially as a relieving officer), and general aptitude for the work. A number of authorities seek to fill these posts with persons holding a university social science degree, diploma or certificate. There is likewise no recognised qualification for duly authorised officers or authorised officers, but under the National Joint Council Scheme for administrative, professional and technical grades the diploma or certificate of a British university in mental health (the psychiatric social work qualification) or in social science is named as an appropriate qualification for a 'mental health worker' in England and Wales—that is to say, officers engaged in work with the mentally defective, or in care and after-care of the mentally ill, whether or not combined with duties as a duly authorised officer.

333. About 40 per cent of welfare officers and mental welfare officers held various qualifications, the most important of which are set out in Table 42. In England and Wales the most frequently held, especially by senior officers and duly authorised or authorised officers, were the relieving officer's certificate, and in Scotland the Scottish poor law diploma. A proportion of officers held the diploma in public administration and a few had taken the Local Government Examinations Board administrative and clerical examinations

Of all these officers, 8 per cent held a social science qualification. This proportion was higher (14 per cent) among mental welfare officers and especially among those whose duties did not include acting as duly authorised or authorised officers, 50 of whom (25 per cent) were so qualified. One senior mental welfare officer was a qualified psychiatric social worker, and one had taken a training in family casework. Ten welfare officers (7 of whom were also mental welfare officers) held the home teaching certificate of the College of Teachers of the Blind. Sixty per cent of welfare officers without mental health duties, nearly 70 per cent of those with combined duties, and 53 per cent of mental welfare officers with mental health duties only had no qualifications, although many had long experience of the work. The proportion of assistants without qualifications was even higher. This situation is made graver by the almost complete absence of in-service training.

Administrative officers with some social work functions

334. Local authorities provided information regarding 209 administrative officers (167 in England, 17 in Wales, and 25 in Scotland), nearly a quarter of whom were regarded primarily as social workers. Rather under half of these (47 per cent) also had visiting duties. The majority of these officers were employed in the welfare services, principally in relation to residential and temporary accommodation where they formed a considerable proportion of the staff employed, and also in work with the handicapped. A number were employed in the health services, particularly the mental health services, either separately or in conjunction with welfare duties, as shown in Table 7.

335. This group was not a homogeneous one, and included a number of senior officers as well as some who held junior posts as assistants to welfare officers. Many of the senior posts were held by officers with Poor Law experience or holding the diploma in public administration. Age ranges are shown in Table 41 and qualifications in Table 42. About 80 per cent of these officers were men.

Workers with the blind

336. Figures provided by the Ministry of Health and the Department of Health for Scotland give the number of home teachers of the blind on 31st December, 1957, as 736 in England and Wales and 78 in Scotland. Not all of these were included in the replies to our questionnaire because of the variety of arrangements between local authorities and voluntary organisations in providing this service and in employing home teachers. We were given details of 601 home teachers of the blind, or about 80 per cent of those in England and Wales, and less than 20 per cent in Scotland, where direct employment by local authorities is the exception. Of these 35 held senior or supervisory posts and 15 were trainee or assistant home teachers. In addition, replies included 5 placement officers, 2 welfare officers for the blind, and 3 superintendents of workshops for the blind. All of these, with the exception of the superintendents of workshops, were regarded by most authorities as being primarily social workers.

337. All home teachers and trainees had visiting duties, 85 per cent of them exclusively. About 60 per cent of superintendent or senior home teachers retained some visiting duties in addition to their administrative and supervisory work. The majority of home teachers were single women, though 15 senior posts and 64 others were held by men.

Table 7: Numbers of administrative officers with some social work functions

Range of duties	All 3 countries			England			Wales			Scotland		
	Total	Counties	County boroughs and large burghs	Total	Counties	County boroughs	Total	Counties	County boroughs	Total	Counties	Large burghs
Welfare services only ...	133	72	61	114	60	54	12	12	—	7	—	7
Welfare and health services	33	10	23	16	6	10	2	1	1	15	3	12
Health services only ...	43	17	26	37	15	22	3	2	1	3	—	3
Total	209	99	110	167	81	86	17	15	2	25	3	22

338. The qualification for work with the blind is the Home Teaching Certificate of the College of Teachers of the Blind. This was held by 60 per cent of superintendent or senior officers and 94 per cent of other home teachers. Other qualifications were infrequent. Two superintendents and 7 home teachers held a university social science qualification: 3 of these home teachers had taken a full-time university course with practical work. One superintendent and four home teachers held handicraft qualifications. The trainee home teachers were as yet unqualified.

Workers with the deaf

339. The services for the deaf are provided as a general rule by voluntary organisations acting under an agency or other arrangement. The National Council of Missioners and Welfare Officers to the Deaf stated in evidence that about 150 of their members were working in England and Wales. Only 6 officers were entered in replies to the questionnaire as employed whole-time by local authorities for work with the deaf, and 2 as shared with voluntary organisations. Of these 8 officers, one employed whole-time and one employed on a shared basis held the certificate or diploma of the Deaf Welfare Examination Board.

Workers with the general classes of handicapped persons (other than welfare officers)

340. Replies to the questionnaire gave details of 87 home visitors for the handicapped, including 3 employed part-time, concentrated mainly in the industrial north (especially in county boroughs), in London and the home counties, and in industrial Wales. The majority were employed primarily as social workers. Thirty-four of them were men, and 53 women of whom 39 were single. A high proportion (31 per cent) held a social science certificate or diploma, 2 were trained almoners and 5 were qualified home teachers of the blind. Other qualifications included handicrafts, and nursing; 53 per cent were not qualified apart from experience.

341. Details were also given of 95 occupational therapists or craft instructors and 37 pastimes organisers or handicrafts instructors. These are not further analysed. We consider the contribution of these officers in the services for the handicapped in paragraphs 546–548.

Psychiatric social workers

342. Twenty-six psychiatric social workers were employed whole-time and 5 part-time in local authority health departments. In 1951 the Committee on Social Workers in the Mental Health Services recorded only 8. All these officers undertake community care of the mentally ill under the National Health Service Acts: two officers employed in Scotland also had duties under the Mental Deficiency Acts, and two in England acted also as duly authorised officers. The replies also recorded 16 psychiatric social workers whose services were shared between local authority health departments and other bodies, 12 of which were hospital authorities. There is known, however, to be a wide variety of administrative and financial arrangements in such sharing, and our information may well be incomplete.

343. Nine English and two Welsh county councils, 14 English county borough councils, and 1 Scottish county council employed, or shared the services of, these 47 psychiatric social workers. These were mainly large authorities, and included only 3 of the 91 authorities with populations of less than 100,000.

These psychiatric social workers, unlike almoners, were not markedly concentrated in any one part of the country (see paragraph 346) though on the whole the North of England and Scotland are less well served than the Midlands and South of England, and Wales.

344. In addition to professionally trained workers, 8 officers who do not hold the professional qualification of a psychiatric social worker were employed whole-time in community care, and 2 were recorded as shared with hospitals and voluntary agencies. All these officers held a social science qualification, one was a qualified almoner, and four had taken a training in family casework.

Almoners

345. Fifty almoners registered with the Institute of Almoners were employed whole-time in health and welfare departments, two in large burghs in Scotland, and 1 in Wales All the rest worked in England. In addition 6 almoners were employed part-time by local authorities. The services of 14 others were shared between local authority health departments and other bodies (12 of which were hospital authorities): these figures, however, may well be incomplete. The functions of these almoners included after-care of the tuberculous (on which nearly half were solely engaged), work with persons suffering with venereal disease, with unmarried mothers, and other general duties. The numbers engaged in various combinations of these duties either whole-time, part-time or shared with other authorities are shown in Table 8. The 2 almoners in Scotland were employed on general duties including work with the tuberculous and with unmarried mothers: the almoner in Wales on similar duties excluding work with the tuberculous.

Table 8: Numbers of almoners employed in various duties

Range of duties	Almoners registered with the Institute of Almoners			Other social workers in the after-care services		
	Total	Counties	County boroughs and large burghs	Total	Counties	County boroughs
Tuberculosis only	32	26	6	45	32	13
Venereal disease only ...	4	1	3	12	5	7
Unmarried mothers only ...	—	—	—	8	5	3
Venereal disease and unmarried mothers ...	4	4	—	2	1	1
General, including tuberculosis and unmarried mothers	3	1	2	4	2	2
General, including tuberculosis, not unmarried mothers	22	18	4	6	4	2
General, including unmarried mothers not tuberculosis	4	2	2	2	—	2
General, excluding both tuberculosis and unmarried mothers ...	1	—	1	3	—	3
Total	70	52	18	82	49	33

346. Sixty-three per cent of almoners in health and welfare departments worked in London and the surrounding counties. The 16 English counties, 9 English county boroughs and 2 large burghs in Scotland which employed almoners included only 2 of the 91 authorities with populations of less than 100,000: the 9 English county boroughs were all in the middle range (50,000–500,000) population. Some of the largest cities in England did not employ almoners.

347. In addition to almoners, 70 other social workers were employed full-time in the after-care services and 3 part-time; 6 were shared with hospital authorities, and 3 with voluntary bodies. All of these worked in England. Of these 82 officers, 30 held a social science qualification. Their duties, as shown in Table 8, were mainly in the tuberculosis service.

348. The majority of almoners and of other social workers in health departments were single women. One man was employed as a qualified almoner and 4 as social workers. The age distribution of almoners, as shown in Table 41, was very similar to that of psychiatric social workers: the age distribution of other social workers resembled that of welfare officers and mental welfare officers, with a high proportion in the older age groups.

Social workers with families, including 'problem' families

349. Fifteen officers, all women, were directly employed to undertake social work with families. One was a trained family caseworker, and 4 held a social science qualification.

Home help organisers

350. Our information relates to 184 home help organisers (including 5 employed part-time) and 292 deputy or assistant home help organisers (including 19 employed part-time). Not all authorities included these officers in their replies, and these figures are not complete. In addition, replies referred to 30 superintendent health visitors or nursing officers whose duties included the organisation of the home help service. Twenty-two welfare officers acted also as home help organisers. Authorities were about equally divided between those who regarded the social work functions of home help organisers as primary or subsidiary. Eighty per cent of home help organisers, and 96 per cent of deputies or assistants, had visiting duties, combined as a rule with administrative and supervisory functions. Only 2 men (apart from welfare officers) were employed, and the proportion of married women and widows was noticeably high. Nearly 70 per cent of organisers and deputies were over 40 years of age (see Table 41). About a quarter of home help organisers, and only 10 per cent of deputies or assistants, had a recognised qualification. Eight per cent of organisers had a social science qualification, 10 per cent nursing, health visiting, or mental nursing qualifications, and 2 per cent domestic science qualifications. The equivalent figures for deputies and assistants were 3 per cent, 4 per cent and nil.

Staff of residential accommodation

351. It was evident from the returns that a high proportion of local authorities regarded staff in residential accommodation under the National Assistance Act as performing a social work function subsidiary to their main employment. Details were given of 326 superintendents, matrons, wardens or deputies in residential or temporary accommodation provided under the

National Assistance Act, 1948. All except 9 of these were in England (7 in Wales and 2 in Scotland). Less than 20 per cent were regarded as primarily social workers. Of these officers 30 per cent were men, and 70 per cent women. Seventy per cent had no recognised qualification, 27 per cent had nursing, and 2 per cent mental nursing, training. A few held the Poor Law certificate for Institution and Hospital Officers, or had taken the Local Government Examinations Board's clerical examination (3 per cent) and a number had taken courses run by the National Old People's Welfare Council; one had a social science qualification. Information was also given about 10 matrons or sisters in charge of mother and baby homes.

Visitors to residential accommodation

352. Replies referred to 7 officers employed by 4 English county councils and 1 English county borough to visit residents in accommodation provided under the National Assistance Act.

Occupation centre staff

353. Fifty-five supervisors and 78 assistant supervisors of occupation centres in England and Wales were included in the replies. The position is not comparable in Scotland where (as noted in paragraph 215) responsibility for trainable mental defectives rests with the education authority. On 31st December, 1957, there were 377 occupation and training centres in England and Wales, of which 293 were full-time. The majority of authorities must therefore have regarded such supervisory staff as having a function other than social work. Details of these officers have not been further analysed, but we consider their contribution in the service in paragraphs 454 and 711.

Nursing staff, including health visitors

354. Seven hundred and sixty health visitors were included in the replies. Over half of these (464) were returned by 12 authorities[1], and were shown as employed on the general duties of health visitors under Sections 22 and 24 of the National Health Service Acts. In the remaining replies they were shown as engaged on a variety of specific duties in connection with tuberculosis, unmarried mothers and venereal disease, 'problem' families, old people, and the handicapped, as well as general health visiting duties for the health department or for a combined health and welfare department. Nearly 30 per cent of the tuberculosis visitors listed in the returns were employed by Scottish authorities. In addition to those listed above, 30 nursing officers undertook the duties of home help organisers (see paragraph 350).

Other officers

355. In addition, information was given on a small number of other officers with miscellaneous duties not covered by the categories above. These included officers providing gadgets or other practical aids for the physically handicapped.

Employment of men and women and of part-time officers

356. Table 43 brings together the information on the employment of men and women and of part-time officers with particular reference to the employment of married women in part-time work. Of the officers considered in

[1] 2 county councils and 4 county borough councils in England: 1 county council and 2 county borough councils in Wales: 1 county council and the councils of 2 large burghs in Scotland.

that table 52 per cent were men and 48 per cent women, but the proportions varied from one group to another. For example, most welfare officers and administrative officers were men, while almoners, workers with the blind and home help organisers were predominantly women. Sixty-six per cent of women officers were single and 34 per cent married (including some who were widowed or divorced). Married women played an important role as home help organisers but few were found among almoners and workers with the blind.

357. As shown by the central columns of the table the proportions of whole-time, shared and part-time staff also varied. Two hundred and twelve staff were shared with other authorities or organisations (6·1 per cent). Of these, 80 workers with the blind were shared with voluntary organisations: 70 welfare officers in Scotland were also district council clerks: and 40 psychiatric social workers, almoners, and other officers in related fields were shared with hospitals or other bodies. Only 79 staff (2·3 per cent) were employed part-time, of whom about one-third were home help organisers. As shown in the right-hand columns of the table, over one-half of the part-time workers were married women.

358. Reference has been made above to the age distribution of various groups of officers considered separately. Taking these together the proportion in the three 10 year bands between the ages of 30 and 60 was much the same for men as for women, but there were notably more women (11 per cent) than men (6 per cent) under 30 years of age and notably more men (13 per cent) than women (5 per cent) over 60 years of age.

Officers with a social science qualification

359. It is a matter of interest to consider where, and in what capacity, officers with a social science qualification are employed. Table 44 shows the numbers and percentage of officers in various occupations who held social science degrees, diplomas or certificates, excluding social workers with a professional training, for which a university social science qualification is almost invariably a prerequisite. The proportion was significantly high among officers with mental health duties only, in comparison with welfare officers with or without mental welfare duties. There was also a high proportion among home visitors for the handicapped. We have referred in paragraphs 283, 284 and 302 to the central government departments' circulars suggesting that such qualifications were appropriate to this work. Numbers were small among workers with the blind.

360. Officers with social science qualifications were not uniformly distributed throughout England, Wales and Scotland. They were most frequently employed by the larger authorities. For example, in England and Wales, they were employed by 18 per cent of county councils and 27 per cent of county boroughs with populations under 100,000; by 66 per cent of county councils and 68 per cent of county boroughs with populations between 100,000 and 500,000; and 82 per cent of county councils and 100 per cent of county boroughs with populations in excess of 500,000. A similar pattern was shown in Scotland, though the percentage of smaller authorities employing officers with these qualifications was less than in England and Wales.

361. Table 9 shows the age distribution of officers with selected qualifications including social science qualifications. We are encouraged to note that among

officers who have taken a full-time social science course with practical work there was a larger proportion under 30 years of age than in any other 10 year age band: the increased recruitment of workers with these qualifications entering the health and welfare services is shown by the fact that they comprise only 7 per cent of all social workers, but over 20 per cent of those under 30 years of age.

Table 9: Ages of officers with various selected qualifications

Qualifications	Number in group	Percentage of relevant total in age ranges				
		Under 30 years	30/39 years	40/49 years	50/59 years	60 years and over
Relieving officer's certificate ...	354	(0·3)	8	41	34	17
Scottish poor law diploma ...	64	—	6	51	30	13
Diploma in public administration	87	2	48	44	6	—
Social science degree, diploma or certificate						
(A) by full-time study with practical work	214	37	31	22	10	(0·5)
(B) by extramural part-time study with practical work ...	43	21	16	37	21	5
(C) as (B) but without practical work	52	6	40	35	19	—

SALARIES

362. We now summarise the information in replies to our questionnaire on salaries paid at 1st May, 1956. This is set out in Table 45, which shows, for all classes of staff concerned, the proportions of officers with salary maxima in successive bands and the proportion of higher paid posts, and thus presents a broad picture of the salary structure. Further details and discussion of the salaries of separate categories of officers are given in the text.

Determination of salary scales

363. The bodies primarily concerned with determining the salaries of officers within our terms of reference in England and Wales (outside London) are the National Joint Council for Local Authorities' Administrative, Professional, Technical and Clerical Services and the Negotiating Committee for Chief Officers of Local Authorities. The salaries of officers employed by the London County Council have since late 1957 been negotiated within the framework of the National Joint Council, though negotiated separately at the time of the questionnaire. In Scotland the Joint Negotiating Committee for Chief Officers does not recommend scales for chief officers whose salaries are determined at the discretion of the employing authority. The National Joint (Industrial) Councils for Local Authority Services (Scotland) corresponds to the National Joint Council in England and Wales. Salaries for psychiatric social workers and almoners are negotiated by the Professional and Technical Council " A " of the Whitley Councils for the Health Services (Great Britain). Further details of negotiated scales are shown in Appendix E.

Chief welfare officers and their deputies

364. Replies to the questionnaire showed that the majority of these officers were paid on either chief officer or administrative, professional and technical (A.P.T.) scales (see Table 10). A few were paid on a personal scale. Table 45 shows 60 per cent (142 officers) on scales with maxima of £1,000 per annum or over, 24 per cent (58 officers) on scales with maxima of £1,500 per annum or over and 8 per cent (18 officers) on scales with maxima of £2,000 per annum or over.

Welfare officers and mental welfare officers

365. Salary scales for these officers are also set out in Table 10. Nearly 90 per cent of welfare officers and mental welfare officers, and nearly 60 per cent of assistants, were paid on administrative, professional or technical scales, or on London County Council social worker scales. The remainder were paid on general, higher general, clerical or miscellaneous scales (the lower scales particularly applying to assistants) with a few on personal or sessional scales. The National Joint Council's scheme of conditions of service provided, on 1st May, 1956, for the grading of welfare officers without mental health duties in A.P.T.II (£595—£675 per annum) and of duly authorised officers in A.P.T.III (£670—£765 per annum).[1] The grading of higher posts was left to authorities' discretion. The effect of these provisions is shown in Table 45. The proportion of posts in England and Wales (outside London) graded as A.P.T.IV (£710—£885 per annum) and above was 16 per cent of welfare officer posts, 7 per cent of combined welfare officer and mental health officer posts, and 9 per cent of mental welfare officer posts: the overall percentage (excluding assistants) was 11 per cent. These figures may be compared with the statement in paragraph 329 that 7 per cent of mental welfare officer posts were designated as senior posts: most of these, and some other posts as mental welfare officer, were graded as A.P.T.IV. In Scotland, where local authorities apply the grades at their discretion, salaries were spread out over a wider range but the average level was very similar; officers undertaking the combined functions of welfare officer, authorised officer and district clerk contained the highest proportion (58 per cent) of any group of welfare officers on scales with maxima of £800 per annum or over. In London, welfare officers were placed in grade IA of the London County Council social worker scales (£528 15s. 0d.—£705 per annum) and duly authorised officers in grade IV (£775 10s. 0d.—£987 per annum).[1] In all three countries, 15 officers in the whole group were paid on scales with maxima of £1,000 per annum or over.

Administrative officers with some social work functions

366. As already noted (paragraph 335) officers returned under this heading included a proportion of junior officers. These were paid on general, higher general or clerical scales. Senior officers in this group were paid on the higher A.P.T. grades or on personal salaries. The application of these scales is shown in Table 10, and salary maxima in Table 45. Seventeen officers in this small group were on scales with maxima of £1,000 per annum or over—more than in the whole of the much larger group of welfare officers and mental welfare officers.

[1] These gradings and scales have since changed: see Appendix E.

Table 10: Salary scales of chief welfare officers, welfare officers, mental welfare officers and administrative officers with some social work functions

Designation	Number for whom information given		Number paid on salary scales as under					
	England and Wales	Scotland	Chief officer	Scottish chief officer	A.P.T.	Scottish A.P.T.	London County Council social worker	Personal, sessional or other
1. Welfare officers responsible for administration of the welfare services:								
(*a*) both to council and for day-to-day administration ...	96	21	46	7	40	13	—	11
(*b*) for day-to-day administration only	38	16	9	4	28	11	—	2
(*c*) as deputy to either of above...	66	2	8	—	55	1	—	4
Total of 1 (*a*)–(*c*)	200	39	63	11	123	25	—	17
2. (*a*) welfare officers	331	18	—	—	276	11	29	33
(*b*) welfare officers also acting as mental welfare officers	293	126	—	—	292	95	—	32
(*c*) mental welfare officers	618	5	—	—	524	2	53	44
(*d*) assistants to any of above... ...	170	45	—	—	116	2	6	91
Total of 2 (*a*)–(*d*)	1,412	194	—	—	1,208	110	88	200
3. Administrative officers with some social work functions	184	25	—	—	139	3	3	64

Home teachers of the blind

367. The National Joint Council's scheme provides for the grading of home teachers of the blind in England and Wales outside London in accordance with A.P.T.I, and 94 per cent of home teachers were paid either on this scale, or on Scottish A.P.T.I scales or on London County Council social worker scales. Senior and superintendent home teachers were all paid on A.P.T. scales (or London County Council social worker scales), frequently on the higher grades ; 3 had salaries in excess of £1,000 per annum.

Workers with the deaf

368. Salaries were paid on A.P.T.II (3 officers), III (1), and IV (2) ; miscellaneous classes (1), and personal or sessional (1).

Home visitors for the handicapped (other than welfare officers)

369. Of 87 home visitors for the handicapped 52 (60 per cent) were paid on A.P.T. scales, mainly on A.P.T.I, and the rest on other National Joint Council scales, or on personal or sessional scales.

Psychiatric social workers and other social workers employed in community care

370. Salary scales for psychiatric social workers and other social workers employed in psychiatric departments and clinics by hospitals and by local health and education authorities are negotiated by the Professional and Technical Council "A" of the Whitley Councils for the Health Services (Great Britain). Details of salaries are given in Appendix E. Replies to our questionnaire showed that 39 psychiatric social workers were paid on Whitley scales—36 on the scale for psychiatric social workers (qualified) (£495—£750 per annum) and 3 on the senior scales (£645—£850 per annum). Six psychiatric social workers were paid on A.P.T. scales, four of them on A.P.T.II (£595—£675 per annum), 1 on A.P.T.III (£640—£765 per annum), and 1 on A.P.T.VI (£880—£1,080 per annum). The lower A.P.T. ranges have higher minima, and the upper ranges higher maxima, than the Whitley scales. One large county borough employed psychiatric social workers as social workers, so that they might be graded on A.P.T. scales and thus benefit from higher starting salaries.

371. Of 10 other officers employed in community care, 8 were paid on A.P.T. scales (2 on A.P.T.I, 5 on A.P.T.II, and 1 on A.P.T.III) and 2 on the Whitley scale for other social workers employed in psychiatric departments and clinics (£420—£635 per annum).

Almoners and other social workers in the after-care services

372. The Professional and Technical Council "A" also negotiates salaries for almoners and for "those persons who, although they do not possess the qualifications for almoners . . . are employed . . . on the duties of that

class." On 1st May, 1956, 49 qualified almoners were paid on Whitley scales as under:

16 as almoner (qualified) (£435—£535 per annum)
1 as senior almoner (£515—£615 per annum)
25 as almoner in sole charge (£515—£675 per annum)
4 as head almoner II (£590—£740 per annum)
3 on unspecified Whitley grades

and 11 on A.P.T. scales as under:

4 on A.P.T.I (£530—£610 per annum)
7 on A.P.T.II (£595—£675 per annum).

Of 82 other social workers in the after-care services, 33 were paid on A.P.T. scales, 23 on L.C.C. social worker scales, 12 on the appropriate Whitley scale and 14 on other scales. As shown in Table 45 the proportion of officers with salaries below £500 per annum and the proportion of officers with salaries of £700 per annum or over was higher in this group than among those trained as almoners.

Social workers with families

373. The salaries of only 12 of these workers were recorded. These were on various scales, including A.P.T.I, II and III, and that for the clerical division.

Home help organisers

374. The National Joint Council Scheme does not provide for the grading of home help organisers, holding that "a standard grading is not appropriate at the present time", and salaries remain at the discretion of individual employing authorities. In London, the London County Council social worker scales are not applied, and organisers and their deputies are paid on special scales. In England and Wales (outside London) 78 per cent of home help organisers were paid on A.P.T. scales (52 per cent on A.P.T.I and 19 per cent on A.P.T.II). Grading of deputy and assistant home help organisers was mainly on miscellaneous grades (39 per cent) or A.P.T. (42 per cent, with 38 per cent on A.P.T.I). The remainder of both groups were, with few exceptions, paid on other National Joint Council, personal or sessional scales.

WORKING CONDITIONS OF FIELD WORKERS

375. It was not possible for us to make a detailed study of all aspects of the working conditions of social workers in local authority health and welfare departments. We have therefore concentrated our attention firstly on the case loads of field workers and the way in which their working time was spent, and secondly on the extent to which they were provided with certain specified facilities. Our information comes from replies to the questionnaire to local authorities, from the surveys of the investigators supplemented by our own experience on visits to local authorities, and from the evidence of a number of witnesses.

CASE LOADS AND ANALYSES OF WORKING TIME

376. Our information on case loads is presented as a set of examples from the different areas. We have not attempted to draw comparisons, which

might well be misleading in view of local differences in range of functions, travelling time and transport facilities, and in the absence of any recognised criteria for differentiating complex and straightforward cases and long-term and short-term work in a total case load.

377. For the analysis of division of working time we are indebted to the numerous field workers in the areas surveyed who kept logbooks, under previously agreed headings, over the period of a fortnight. We are well aware of the burden which recording these details imposed on busy officers and should like here to express our appreciation to these field workers for their help. These logbooks provided much valuable information on the way in which their time was divided between various aspects of the work. In spite of local differences the information from different areas is broadly in agreement on such points, for example, as the proportion of time spent in travelling compared with that spent in contact with clients.

Welfare officers and mental welfare officers

378. In one county, 10 district welfare officers were shared equally by health and welfare departments. The areas in which they worked were partly urban and partly rural. As officers of the health department they acted as duly authorised officers under the Lunacy and Mental Treatment Acts, and their other duties included visiting and helping patients discharged from mental hospitals, and visiting mental defectives under voluntary or statutory supervision. The ascertainment of mental defect, and the visiting of those under guardianship or on licence, was undertaken by other officers. As officers of the welfare department they were responsible for visiting, assessing and reporting on applications for admission to residential and temporary accommodation under Part III of the National Assistance Act and for collecting the charges which such residents were assessed to pay; for ascertaining the needs of the physically handicapped, recommending registration when appropriate, obtaining any necessary assistance, and visiting regularly those in need of help. In addition they had duties in regard to civil defence.

379. Details of individual case loads in terms of handicapped persons, of the mentally defective and of the mentally ill are given in Table 50. The wide differences both in relative and absolute numbers in these three categories between case loads of officers with the same range of functions and in the same authority shows the difficulty of making any general comparisons. Table 51 shows visits and interviews by these officers over a three-month period and brings out clearly, under the heading of 'other inquiries', the number of contacts with the public falling outside their statutory duties.

380. Each of these officers had a car, an office where interviews could be conducted with privacy, and a telephone line or extension. No clerical assistance was normally provided and much time was spent in writing or typing letters or reports. The average percentage of time spent by 8 of these officers on various aspects of the work is shown in Table 11, followed by the minimum and maximum in individual instances.

Table 11: Welfare officers/mental welfare officers in mixed urban and rural areas (division of working time)

	Percentage of time spent	
	average	minimum and maximum
Travel	19	8—29
Contact with client	31	26—37
Discussion of cases with colleagues	8	3—15
Letter writing, record keeping and administration generally	42	27—61

381. In another, more rural area, 8 officers were employed, likewise with combined welfare and mental health duties, but with entire responsibility for the service to mental defectives including general supervision and arrangements for institutional care. Five provided services for the general classes of handicapped persons. About half their time was given to supervision of mental defectives, and about a quarter to duties under the Lunacy and Mental Treatment Act, which necessitated their being available on rota for night and week-end calls. With one or two exceptions these officers had the use of cars. A summary of the average number of cases and visits paid in a year is given in Table 12.

Table 12: Welfare officers/mental welfare officers in a rural area (average number of cases and of visits paid in a year)

Service	Number of		
	cases	visits annually	removals to hospital annually
General classes of handicapped persons (average for 5 officers)	22	40	—
Residential care	82	232	—
Mental deficiency	102	315	—
Mental illness	75	173	78

382. The division of working time is shown in Table 13.

Table 13: Welfare officers/mental welfare officers in a rural area (division of working time)

	Percentage of time spent	
	average	minimum and maximum
Travel	20	11—26
Contact with client	20	9—27
Discussion of cases with colleagues	13	5—29
Letter writing, record keeping and administration generally	47	30—60

383. A complete contrast was provided by a city area where the mental health and mental deficiency services were provided by separate staff. Here duly authorised officers, working on a shift system, each dealt with approximately

600 referrals annually under the Lunacy and Mental Treatment Acts. About half of these patients were admitted to observation wards, and 23 per cent required no action. While on day shift each officer dealt with three to four cases per day. The length of time spent on each varied considerably. It might require only a short time to remove a deluded schizophrenic who was quite out of touch with reality and whose relatives recognised the necessity of hospital care. It might on the other hand take an hour to persuade a suspicious or very distressed patient who was well in touch with his environment to go to hospital immediately in order to receive treatment. Interviews with relatives were conducted in a room shared with other officers. Telephones were provided but no clerical help. Travel was mainly by car. The division of working time for five of these officers is shown in Table 14.

Table 14: Duly authorised officers in a city area (division of working time)

	Percentage of time spent	
	average	minimum and maximum
Travel	27	21—34
Contact with client	19	15—30
Discussion of cases with colleagues	18	10—23
Letter writing, record keeping and administration generally	36	24—47

384. In the same area 8 mental deficiency officers had a combined case load of 1,100 mental defectives subject to statutory supervision, and about 400 under voluntary supervision. In addition they undertook investigation of the home conditions of defectives who were considered ready for discharge from hospital or whose relatives had applied for their release on licence. These visitors (two of whom completed logbooks) carried an average case load of 200 cases, their visits varying in frequency from one a month to one a year. On the average, statutory supervision cases were visited five to six times a year. Travel was mainly by public transport. No clerical help was available. The division of working time for 3 of these officers is shown in Table 15.

Table 15: Mental deficiency officers in a city area (division of working time)

	Percentage of time spent	
	by local organiser	by mental deficiency visitors (average of 2)
Travel	6	18
Contact with client	30[1]	23
Discussion of cases with colleagues	30	14
Letter writing, record keeping and administration generally	34	45

[1] Including 9 per cent. at occupation centres.

385. A summary of the division of working time of 24 of these officers is given in Table 16.

Table 16: Welfare officers/mental welfare officers (division of working time)

Nature of area	Number and designation of officers	Percentage of time spent			
		Travel	Contact with clients	Discussion with colleagues	Letter writing, record keeping and administration generally
Mixed rural and urban	8 welfare officers/mental welfare officers	19	31	8	42
Mainly rural	8 welfare officers/mental welfare officers	20	20	13	47
City	5 duly authorised officers only	27	19	18	36
City	3 mental deficiency officers only	14	25	19	42
	Average	20	24	13	43

386. In another area, partly urban and partly rural, the case load of a duly authorised officer consisted of some 200 admissions to mental hospitals each year, combined with the supervision of 110 adult male mental defectives and a few patients referred for after-care by mental hospitals.

387. Some of the district welfare officers considered so far, undertook duties under the National Assistance Act as well as mental health duties, but these did not include services for the blind and the deaf. Figures relating to a rural county where these services were provided by district welfare officers are therefore interesting for purposes of comparison. The case loads of ten officers are shown in Table 17. In addition to the services there listed, these officers were responsible for visiting old people awaiting admission to residential care; for removal and after-care of mentally ill persons, and for home help inquiries locally.

Table 17: District welfare officers in a mainly rural county: case loads

Nature of district	Size of area (acres)	Population	Number of officers	Case load					
				Blind	Partially sighted	Deaf	General classes of handicapped persons	Mental Defectives	
								Statutory supervision	Voluntary supervision
Urban ...	5,640	43,740	2	134	32	43	42	17	9
Mixed ...	50,733	19,710	1	52	6	12	30	15	13
Mixed ...	20,000	16,430	1	58	14	18	83	8	7
Mixed ...	75,000	27,000	1	48	17	26	25	17	10
Rural ...	45,299	17,680	1	35	11	11	22	12	10
Rural ...	100,896	18,680	1	72	15	19	43	20	15
Rural ...	80,188	26,870	1	58	25	23	26	18	11
Rural ...	65,000	22,900	1	47	13	23	42	14	5
Rural ...	106,187	27,690	1	72[1]	20[1]	24	26	23	21
Average (per officer)	—	22,070	—	58	15	20	34	14	10

[1] In this district instruction in braille and moon is given by one of the other officers.

388. In this area logbooks were not kept. We were, however, given details about travelling distances. In 1953–54 the total case load was 1,106; the number of visits paid was 5,900 and mileage covered was 101,225 (17·2 miles per visit). Since then district welfare officers have progressively taken on duties as home teachers of the blind and as home visitors for the deaf. By 1956–57 the total case load had risen to 1,512 and the number of visits paid to 7,120. The total distance travelled had fallen to 62,836 miles (8·8 miles per visit). We estimate that this amount of travelling involved about 200 hours of driving for each officer annually, or about 10 per cent of working time. On the same basis in 1953–54 each officer would have spent nearly 350 hours annually in travelling, or 18 per cent of working time.

Home teachers of the blind

389. Table 18 shows average case loads of home teachers in four county areas ranging from extremely rural to partly urban: the average was 144 blind and 35 partially sighted persons. In a fifth area in a large city the case loads of three home teachers of the blind ranged from 200 to 250, including partially sighted, and the majority were visited once in 7–12 weeks. Very lonely people were visited more often, usually at weekly or fortnightly intervals. In this area, however, home teachers were not responsible for administrative and clerical work (including letter writing) which was undertaken by a separate officer.

Table 18: Home teachers of the blind in four county areas: case loads

Number of home teachers in area	Average number per home teacher of	
	Registered blind persons	Partially sighted persons
7	143	22
6[1]	111	40
2	96	33
11	180	42

[1] Of these, 2 had deaf and hard-of-hearing persons in their case loads (20 in one instance 33 in the other).

390. The proportion of blind persons who were being taught braille, moon or handicrafts varied greatly. In the area in which it was highest, 11·7 per cent of blind persons were noted as having had visits for instruction or rehabilitation over a 12 month period in 1955–56. An analysis of logbooks kept by 7 home teachers in 1957 showed 99 visits with some element of instruction, lasting on an average 55 minutes, and occupying 34 per cent of visiting time, and 362 other visits lasting on an average 29 minutes and occupying 66 per cent of visiting time: these figures, however, give an exaggerated impression of the time spent in instruction, since the whole period of a visit was entered as instructional if even the briefest of lessons was given. Elsewhere the proportion of instruction was less. In one area, out of a case load of 180 less than 10 per cent were being taught braille. In another, 9 out of 450 blind persons (2 per cent) were receiving instruction. In yet another, of 193 blind persons 2 were being taught

braille or moon and 1 was having handicraft lessons—in all 1·5 per cent. were receiving instruction; over the course of a month, 6 per cent of all visits to blind persons in this area were instructional.

391. The division of working time between various aspects of the work is shown in Table 19. In the last of these areas much of the administrative and clerical work was undertaken by a separate officer. Compared with welfare officers and mental welfare officers, far more time was spent in contact with the client, and far less in letter writing, record keeping and administration. Travelling time was about the same.

Table 19: Home teachers of the blind (percentage division of working time)

Number of home teachers in area who kept logbooks	Travel	Contact with clients		Discussions with colleagues	Letter writing, record keeping and administration generally
		At home	In social centres		
7	26	50	6	6	12
6	30	44	10	5	11
2	26	39	4	5	26
1	11	46	22	5	16
3	12	53	16	5	14
Average of total	24	47	10	5	14

Workers with the deaf

392. Our figures relate to two county areas, both mainly rural, though with some urbanisation. In one of these areas two field workers (both using public transport) were employed by the local authority. Each had a case load of about 130 deaf persons and 95 hard-of-hearing. Three social clubs were held weekly, with an attendance at each of about 15. The figures in Table 20 for one of these workers show nearly 50 per cent of working time spent in public transport or walking. In the other area a worker, with the use of a car, had a case load of 243 deaf persons (of whom 62 were children) and 125 hard-of-hearing (including deafened). In this area social activities and religious ministration were provided by the voluntary organisation but the welfare officer for the deaf considered it part of his function to attend. The allocation of his time to various aspects of work is also shown in Table 20. In a third area a worker, employed by a voluntary organisation, had a case load of 93.

Table 20: Workers with the deaf (percentage division of working time)

Number of workers	Travel	Contact with clients	Discussion with colleagues	Letter writing, record keeping and administration generally
1	47	30	8	15
1	20	24	50	6
Average ...	33	27	29	11

Home visitors for the handicapped

393. In most areas duties in relation to the welfare services for the general classes of handicapped persons are combined with more general duties. In three county areas and one city area our information relates to the work of welfare visitors for the handicapped only. In one of the county areas case loads consisted of about 200 handicapped persons of whom about 20 regularly attended social centres. The remainder were visited on the average about every 15 weeks. The workers in this area travelled mainly by public transport. In another, two visitors each with cars had case loads of 272 and 287 of whom 25 and 29 respectively were learning handicrafts. Each visitor paid about 80 to 90 visits a month. In a third area (the most urban part of a county) the home visitor for the handicapped, with a car had a case load of 360. In a city area we have information about two field workers, one with a case load of about 200, and the other with a case load of 280 : these figures have however been reduced by about 40 per cent with the appointment of more staff since the survey was undertaken. The division of time between various aspects of these officers' work is shown in Table 21. As with other workers about 20 per cent of time was spent in travelling (by public transport).

Table 21: Home visitors to the handicapped (percentage division of working time)

Number of visitors	Travel	Contact with clients		Discussion with colleagues	Letter writing, record keeping and administration generally
		At home	In social centres		
2	27	15	22	8	28
2	12	39	14	10	25
1	29	38	—	14	19
1	15	30	4	included in next column	51
Average ...	20	30	12	9	29

Almoners

394. We have information about the case loads and working conditions of almoners from two county areas and one large city. In one county in 1956 three almoners had 786 patients referred for care and after-care, 394 chronic sick and elderly persons for social investigation before admission to hospital or on discharge, and 15 unmarried mothers. The analysis of logbooks of two of these almoners is set out in Table 22. They had access to a typing pool and sometimes also clerical assistance at clinics and hospitals. Transport was by car. We were informed that normally one of these officers spent about as much time travelling as with clients, but that when her car was out of action for a few days travelling time was twice that spent with clients. In the second county one of two almoners had a case load of 364. The analysis of the logbooks of these two almoners is also given in Table 22. Finally, we have information about the work undertaken by two tuberculosis almoners in an urban area working in separate clinics. In one of these, 392 new patients were seen in 1955 with a total number of 2,860 interviews and 1,120 home visits. In the other, 171 new patients were seen, with 1,412 interviews and 20 home visits.

Table 22: Almoners (percentage division of working time)

Number of almoners	Travel	Contact with clients	Discussions with colleagues	Letter writing, record keeping and administration generally
1	37	26	7	30
1	26	24	16	34
1	23	19	15	43
1	32	17	22	29
Average ...	29	22	15	34

Family caseworkers

395. Two family caseworkers, providing intensive help to ' problem ' families in an urbanised part of a county had case loads of 7 and 8 respectively. An analysis of their logbooks is given in Table 23.

Table 23: Family caseworkers (percentage division of working time)

Number of family caseworkers	Travel	Contact with clients	Discussions with colleagues	Letter writing, record keeping and administration generally
1	22	34	7	37
1	24	31	12	33
Average ...	23	32	10	35

Home help organisers

396. The functions of home help organisers in relation to the client are not comparable with those of other officers considered in this chapter, and they cannot be said to have a case load in the same sense. Table 24 shows the division of working time of home help organisers in three areas. The proportion of time spent in contact with clients and in discussion with colleagues was fairly uniform. Much time was spent in letter writing, record keeping and administration generally. In the first area, where one organiser and an assistant covered the whole of a large rural county, and where rather more visiting was undertaken, much time was spent in travelling. In the second area the districts covered were mainly urban, and in the third heavily populated and very compact.

Table 24: Home help organisers (percentage division of working time)

Number of officers in area	Travel	Contact with clients	Discussion with colleagues	Letter writing, record keeping, and administration generally
2	35	20	8	37
8	12	18	6	64
2	6	15	12	67
Average ...	14	18	7	61

GENERAL OBSERVATIONS

397. This information shows that about 20 per cent of field workers' time was spent in travelling: this percentage was not necessarily much less in a town than in the country. In one area where officers with appropriate qualifications undertook general duties travelling time had been nearly halved over 5 years. The time spent by field officers on letter writing, record keeping or other administrative procedures averaged one-third of working time. About one-third to one-half of working time was spent in contact with the client, and a small proportion in discussion with colleagues.

FACILITIES PROVIDED FOR FIELD WORKERS

398. In our questionnaire we asked for information regarding the following facilities for field workers:—

(*a*) regular clerical assistance,
(*b*) official transport (or subsidised use of own car),
(*c*) office telephone,
(*d*) use of a room in which interviews could be held in privacy.

A number of authorities who provided these facilities for some, but not all, of their officers found some difficulty in replying to this question in the form in which it was asked. In preparing the general synopsis in Table 25 we have taken the answers as affirmative only if facilities were, so far as we could judge, provided for all or substantially all field workers.

Table 25: Authorities providing facilities for field workers

Authorities	Health Departments				Welfare Departments			
	England and Wales		Scotland		England and Wales		Scotland	
	County councils	County borough councils	County councils	Councils of large burghs	County councils	County borough councils	County councils	Councils of large burghs
Total replying ...	60	83	24	23	60	83	24	23
Percentage providing								
(*a*) Clerical assistance	52	89	67	83	42	92	75	83
(*b*) Official transport	97	76	67	30	95	83	75	43
(*c*) Office telephone	93	99	75	83	95	100	92	91
(*d*) Private room for interviewing ...	82	74	85	87	90	77	92	83
All four of these facilities	47	66	50	30	38	70	62	35

Clerical assistance

399. Regular clerical assistance was available to most field workers in county boroughs and large burghs, and to over 75 per cent of those in Scottish counties. Although the majority of county councils in England and Wales gave a negative reply, some qualified this by adding that partial help might be available, or that help could be given when necessary: one county council

said that field workers did not enter into correspondence, and another said that, while letters could be typed, reports and other such documents were written by the officers concerned.

400. Many of the officers in the county areas covered by the field studies had no clerical help. Frequently, letters and reports were written by hand or typed by the officer himself. In one area, where no clerical help was provided, duly authorised officers spent from 25 per cent to 47 per cent of their time on letter writing, record keeping and administration generally. We draw attention (paragraph 606) to the general inadequacy of case records, as revealed in the course of our inquiry, and to the vital importance of such records for an efficient and economical service.

Official Transport

401. Official transport of some kind was generally available, particularly in county areas, either by the provision of an official car, or in the form of an allowance for running the worker's own car. Some of the replies, however, appeared to refer under this heading to free public transport which has not the same advantages in saving travelling time. Official transport was provided less frequently in urban than in rural areas.

402. In the areas covered by our inquiries field workers were, with few exceptions, provided with official transport or an allowance for the use of their own car. In one area however—a mixed urban and rural area where in many cases long distances had to be covered—the provision of official transport was exceptional. The logbooks of the field workers showed that this affected the amount of work undertaken. Thus a home teacher of the blind in this area who had the use of a car, spent 10 per cent of her time travelling and averaged about 30 visits to blind people and 2–3 to social centres weekly, whereas a visitor to the deaf who travelled only by public transport or on foot, spent 47 per cent of his time travelling, with a weekly average of 6 visits to deaf people and 2–3 to social centres. In the same area two home visitors to the handicapped, who had the use of a car for some visits, but not all, spent 26 per cent and 28 per cent of their time in travel, paying respectively an average of 8 and 12 visits to individuals and 2–3 to social centres weekly.

Telephone facilities

403. Telephone facilities were provided by most authorities. The evidence of the field studies confirms that telephones were generally available to social workers, though frequently shared with other officers of the same or different departments. Some home teachers of the blind who worked from their own homes, were not officially provided with telephones.

Rooms for interviews

404. Private rooms for interviewing were provided by over 75 per cent of the authorities replying to the questionnaire. In counties the provision was higher in welfare departments than in health departments but the reverse was the case in county boroughs and in large burghs.

405. In the areas surveyed interviewing rooms were available to most officers. Some field workers had no office facilities for interviews and others could conduct interviews only in rooms which were shared with other officers

or with clerks. We draw attention in a later chapter to the need for keeping case records confidential. We consider that the same considerations should apply to interviews between the social worker and client, which should be conducted in privacy and without interruptions.

406. The provision of adequate facilities of the kind considered above has an important bearing on the effective and economical use of staff. We consider the subject further in connection with estimates of staff required, and make recommendations in paragraphs 766 to 769.

Chapter 3

LOCAL AUTHORITY HEALTH AND WELFARE SERVICES: THE PRESENT PICTURE

407. In this chapter we consider first the local organisation of services, and then review briefly the services within our terms of reference and the work of officers employed in them. Our information is derived from evidence and other documentation, replies to the questionnaire, our own observations, and the reports on the field studies. We explained in paragraph 9 why the authorities which we ourselves visited, and the areas surveyed in the field inquiries, were not identified. For the same reason we refer in this chapter in general terms to authorities included in our inquiries.

LOCAL ORGANISATION OF SERVICES

408. The health and welfare services touch the lives of many thousands of families and individuals throughout the year and their organisation and administration are of great importance. Some, such as the maternity and child welfare service, meet normal family requirements, but others support or supplement individual or family effort in time of trouble or disability, or provide residential care for those unable to live in homes of their own. It would be idle to contemplate any standard administrative pattern for services of such range and scope, but we have been impressed by the need for local services to be really local if they are to be well known and readily available to those who need them, and if the staff are to be used both economically and to the best advantage.

409. In the questionnaire we asked about the local arrangements for operating all the health and welfare services, in terms of geographical sub-division of the authority's area, and the functions of local offices. We have regarded authorities having area, district or divisional offices as providing decentralised services, though we recognise that the allocation of districts or areas to field workers based on a central office also implies a measure of decentralisation. We did not consider it feasible to ask for details of such arrangements and our information is therefore incomplete on this point. We are aware, however, that they may be made by more authorities than might appear from the replies.

410. Local arrangements are naturally influenced by the size of authority and distribution of population. Area offices are thus most likely to be found in counties, but the pattern in Scotland is not entirely comparable with that in England and Wales. In many Scottish counties the district welfare officer appointed by the county council is also employed as clerk by the district council, and the extent of decentralisation is usually governed by this practice. These officers also undertake the duties of authorised officers and mental welfare officers.[1] Fifteen out of 26 Scottish counties which replied to the questionnaire have arrangements of this kind. Of the remainder, 6 have some decentralisation (1 with a population under 50,000) and 5 have none (all with populations under 50,000). There is little or no decentralisation in large burghs.

411. Administrative decentralisation in English and Welsh counties is shown according to population and area in Table 39. Seventy-three per cent of the counties in England and Wales which completed the questionnaire have some degree of decentralisation of either health or welfare services. These include all but one of the larger counties and six out of the 21 which have a population under 200,000 and an area of less than 1,000 square miles. In 88 per cent of county boroughs in England and Wales there are no district offices for the health and welfare services, and no reference was made to workers being allocated to districts. Decentralisation is mainly found in the larger and more populous cities, though a few of the largest are centrally administered.

412. The patterns of local organisation and administration are immensely varied and arrangements in the health and welfare services are often different. In the health department (omitting services outside our terms of reference) the home help and mental health services are frequently decentralised in English and Welsh counties, and the latter are often treated differently from other services, being decentralised while others are administered centrally, or *vice versa*. The amount of administrative devolution is small, but local offices generally carry the main responsibility for field work. The majority have direct contacts with the public and also, as a rule, with local offices of other statutory and voluntary organisations. In some authorities, however, all contacts with voluntary organisations are made through the central office.

413. We have mentioned local organisation at the beginning of this chapter because it bears on the functions of different workers and on the degree of co-ordination and team-work that can be achieved. We appreciate that other factors besides social work influence the decision to organise services centrally or locally, nevertheless co-operation in the field depends greatly on ease and frequency of contact between workers. We attach considerable importance to officers knowing the districts in which they work, and being known in them, and easily accessible local offices are particularly useful in this respect; they may substantially reduce workers' travelling time. A local office may also be important to those using the services who might otherwise be forced to travel long distances if they wished to visit the office, or if privacy for an interview made this desirable. The very variable picture shown in the questionnaire returns suggests that if team-work is to be encouraged some thought may have to be given to these practical considerations.

[1] See paragraph 219 for use of these terms.

SOCIAL WORK IN HEALTH CENTRES AND GROUP PRACTICE

414. We referred in paragraph 182 to increasing knowledge of stress diseases and to the significance of social and emotional factors in illness. We referred also (paragraph 188) to experiments in the use of trained social workers in health centres and group practices. Two recent accounts of these experiments provide information about the type of social problem commonly encountered, and illustrate the inter-relation of the work of general practitioners with some local authority services.

415. The social worker at Darbishire House Health Centre[1] in Manchester (who is an almoner) was appointed to assist with the social problems arising in general practice, and to assess the extent to which a social worker could help in their alleviation. The analysis of cases referred to this worker during the first year showed that nearly 50 per cent were related to mental and emotional health, about 15 per cent to resettlement or employment difficulties, 14 per cent to the care of the elderly, aged, and dying, or to the care of the younger chronic sick and handicapped, and 6 per cent to illegitimate pregnancies or too frequent child-bearing. The remainder related to housing, loneliness, need for holidays or convalescence, or to difficulties of family adjustment. A few families were regarded as problem families in that they presented problems either to the doctor on account of excessive anxiety, aggressiveness, or persistent sub-health in the children for which there was no clearly understood cause, or to the community in the more usually accepted sense of the 'problem' family, characterised by low standards of living and child care. There were broadly similar findings in a survey in Northern Ireland in 1957[2]. This survey was aimed at discovering how far a social worker could relieve the general practitioner of social problems, and also at bringing about closer co-operation between general practitioners, local health authority workers, and other social agencies. Of the 417 families in the practice 118 were considered to be in need of some form of social care; in 37 per cent of these, the problems were associated with ill-health or chronic illness, in 11 per cent with old age, in 16 per cent with marital or family friction and in the remainder with housing or financial difficulties, loneliness or inability to maintain personal or family standards. The difficulties of 64 of these families (54 per cent) had not previously come to notice. Obviously only a tentative conclusion on the scope for social work can be drawn from this limited material, but it agrees with what we were told when we visited the General Practice Teaching Unit in Edinburgh, where the family doctor team is built round the general practitioner and an almoner, and also with the experience of some authorities included in our inquiries and referred to in paragraph 417.

416. These experiments indicate that general practice surgeries are key points at which a trained social worker can identify social problems related to sickness and ill-health, sometimes at a comparatively early stage, that is

[1] Darbishire House Health Centre was established jointly by the Nuffield Provincial Hospitals Trust, the Rockefeller Foundation, the University of Manchester and the City of Manchester. It is not provided within the framework of the National Health Service Act.

[2] Social Work in General Practice. T. Dudgeon. *The Medical Officer*, 1957, Vol. 97, 21st June, 1957, and Medical Social Work in a General Practice, E. M. Backett, R. P. Maybin and T. Dudgeon, *The Lancet*, 5th January, 1957.

at the point at which they arise in the home and before a further crisis may be precipitated by a breakdown in family care or admission to hospital. Early identification also facilitates early notification of the local authority services which may later be involved, for example, by the eviction or break-up of a family. In addition, this setting provides an opportunity for effective team-work between general practitioners, almoners and health visitors in particular, and between general practitioners and other local authority workers, such as mental welfare or child care officers, or welfare officers for the handicapped.

417. The arrangements at Darbishire House (where the social worker is whole-time) are at present unique. The line of development elsewhere may prove to be that envisaged in the Report of the Central Health Services Council referred to in paragraph 187, which suggested that the health department ' socio-medical ' worker should attend sessions at health centres. Replies to our questionnaire showed that this is current practice in Edinburgh where the health department almoner attends the health centre for one session a week to assist patients with social or financial problems. The replies also drew our attention to the consultative health centre at Rutherglen where a consultant and local health authority service is provided for the elderly in co-operation with general practitioners. Members of the voluntary old people's welfare committee attend the centre regularly, thereby meeting elderly people of whose existence they may previously have been unaware. They co-operate with health visitors, and undertake home visiting in addition to organising social and other activities at the centre. Another interesting experiment noted in the replies is in Bristol where health department psychiatric social workers attend the health centre and give short talks on various aspects of child care and psychology to mothers at infant welfare sessions and mothercraft clubs.

418. These developments, though still few in number confirm our own view of the scope for local health authority social workers, especially almoners, in these new services.

SOCIAL ASPECTS OF THE CARE OF MOTHERS AND YOUNG CHILDREN: THE UNMARRIED MOTHER AND HER CHILD

419. The importance of the mother-child relationship from birth, and throughout the first years is now generally recognised. With this has come a new emphasis on mental health in maternity and child welfare and on the social aspects of the care of mothers and young children. We referred in paragraph 417 to the contribution of psychiatric social workers in Bristol; similar advisory services for health visitors are provided by psychiatric social workers in the mental health services in Birmingham and Leeds. In London, experimental discussion groups have been arranged between the staff of the Tavistock Clinic and London County Council medical officers and health visitors. In Newcastle-upon-Tyne a proportion of the city almoner's work is referred from the maternity and child welfare service. This includes case-work with pregnant single girls, widows, or separated wives, and with various family problems. The almoner also arranges for convalescence and for the admission of mothers and younger children to recuperative centres such as those at Brentwood or Spofforth Hall (see paragraph 201).

420. Replies to the questionnaire showed that 70 per cent of all authorities use voluntary associations for work with unmarried mothers; in about 27 per cent care is provided on an agency basis. In England these associations are mainly Anglican or Roman Catholic, in Wales and Scotland the Salvation Army is mainly concerned. The latest figures in England and Wales show that local authorities administer 29 mother and baby homes, a small number of which are shared by neighbouring authorities, while 106 are provided by voluntary organisations. Some authorities and voluntary organisations provide hostels from which the mothers can go out to work while their children are cared for, but these are few in number and some have closed recently owing, it is said, to lack of demand. As suitable accommodation for unmarried mothers is usually difficult to find, the closing of these hostels may indicate that some other kind of provision is required, rather than that the need itself no longer exists. Generally speaking, there are drawbacks to any communal facilities which either isolate the mothers from the community or identify them as a group. Some are admitted to temporary accommodation under the National Assistance Act. (Paragraph 499 refers.)

421. An unmarried mother may need help from a variety of local authority workers in addition to a general practitioner or hospital and the National Assistance Board. In the health department, she will usually be known to the staff of the maternity and child welfare service and the health visitor, and also to the almoner or social worker if there is one. She may have to place the child in a day nursery or with a child minder, or she may have problems which require help from the mental health service. The education department will come into the picture if the child remains with his mother, and the children's department if she decides to have him received into care or if she places him in a foster-home where payment is required. Unmarried mothers often need considerable help in coming to a decision about the future care of their children. Close co-operation with the children's department will often be desirable. Officers in the welfare department and in the housing authority may also be involved; the contribution of the latter can be of great importance, though this is not always recognised.

422. The war-time Ministry of Health circular referred to in paragraph 195, suggested, in view of the size of the problem at the time, that authorities should appoint officers qualified to work with unmarried mothers. Replies to the questionnaire and local health authority annual returns showed that, in 1956–57, 16 authorities[1] in England and Wales distinguished staff appointed for this purpose. These consisted of almoners or other social workers undertaking such work as part of a general case load, or health visitors. This is indeed similar to the general pattern of directly administered services throughout the country. None of these officers appeared to have taken a moral welfare training. Five of the authorities included in our inquiries employed almoners or other social workers in addition to co-operating with a moral welfare or other voluntary association. One met half the cost of the moral welfare worker's salary, and a proportion of administrative and other expenses.

[1] This figure is not comparable with that mentioned in paragraph 196 because of the reduced number of responsible authorities under the National Health Service Acts. Nevertheless there is a relative decrease of nearly 50 per cent in the number of local authority officers specifically appointed for work in this field since 1948.

423. Where a number of different workers may all be needed co-ordination of effort is particularly important. The problems of these mothers often require that ante-natal and post-natal care should be provided away from their own locality, and this usually involves a change of doctor and of social worker. Co-operation will often present real practical difficulties in these circumstances. When social work is undertaken by voluntary organisations much depends on the effectiveness of local arrangements in this respect. We were glad to find from the questionnaire replies that moral welfare workers are generally well represented on co-ordinating committees and at case conferences where these arrangements are in use.

424. Married women with extra-marital pregnancies usually present different problems from the unmarried, but their difficulties may be as great or greater. If the child remains with his mother, his well-being will depend to a great extent on his acceptance by the husband and other members of the family. Unsupported mothers, on the other hand, often have similar difficulties to unmarried mothers, especially if there is more than one child. In both groups are to be found the deserted, as well as the socially maladjusted and the mentally dull. Both also share the fundamental problem of lack of a husband and wage earner, and of a father for their children.

425. The particular needs of unmarried mothers have been recognised in the past by the provision of special arrangements for confinement and after-care, mainly through voluntary organisations. The ability of unmarried (or unsupported) mothers to bring up their children successfully will frequently depend on the use they can make of the social services in meeting family and financial responsibilities, finding suitable accommodation and making arrangements for their children while they are at work. From the social aspect, and the need for social work by local authorities, it does not seem to us desirable or necessary to single out unmarried mothers to any greater extent than circumstances make inevitable. Apart from medical or health considerations and arrangements for confinement, we see no advantage in isolating the care of these mothers either from similar work with unsupported mothers, or from the work of a family caseworker employed by the health department. We do not mean by this that the work of the voluntary organisations is no longer required. Good voluntary work, in accord with the need and spirit of the times, will always be important in this field. Changes in social attitudes towards sexual and extra-marital relationships, especially among younger people, call for wise and effective action by various voluntary organisations, as well as by responsible citizens. We see this more general social action as an essential complement to the local authority's own social work.

PREVENTION, CARE AND AFTER-CARE

426. In Chapter I we considered under this heading the general development of the social aspects of the prevention, care and after-care services since 1948 and in particular those which led to the use of social workers for work with families. We then referred to similar aspects of the care of the tuberculous and of those suffering from venereal disease. Finally we outlined the provision for the care of the mentally disordered in the community. In this chapter we group first the after-care of hospital patients referred for social work by hospitals or general practitioners, the tuberculous and those with venereal disease; then social work with families; and lastly the mental health service.

After-care of patients referred for social work by hospitals or general practitioners and of the tuberculous

427. The care and after-care of the sick and of patients discharged from hospital was envisaged as one of the main functions of local health authorities under the National Health Service Acts, in collaboration with the home nursing, home help and health visiting services. Since 1948 there has been an increasing use of these services to assist general practitioners with sickness in the home. Many of the social problems arising from illness which previously came to light on attendance at, or admission to, hospital and were thus the concern of the hospital almoner now require comparable help from the local health authority. There is also an increased emphasis on rehabilitation and resettlement on discharge from hospital (especially of the physically handicapped), on the care of the young chronic sick in the community, and on the after-care of the elderly discharged from geriatric units. These trends increase the demands on the domiciliary health services and indicate the need for complementary social action. In some areas, hospital resettlement conferences help to provide continuity of medical and social care in much the same way as the case conferences between staff of certain mental hospitals and workers in the local authority mental health service. Replies to the questionnaire showed, however, that hospital almoners seldom attend case conferences held by the local authority.

428. Four of the authorities included in our inquiries employed almoners or other social workers whose duties included the after-care of patients referred for social work by hospitals or general practitioners, in addition to similar work with the tuberculous and unmarried mothers. They also undertook social investigation of the chronic sick and elderly awaiting admission to hospital, and arranged for convalescence. In two areas an increasing number of social problems had been referred by general practitioners during the last three years, thus confirming the experience in other medical practices referred to in paragraph 415.

429. In the tuberculosis service recent advances in medicine and better facilities for rehabilitation and resettlement have shortened the time required for medical treatment. The tuberculous patient may still need help, nevertheless, in maintaining standards of living and in dealing with personal stress, or with the social and economic factors which hinder recovery or are sometimes responsible for lack of co-operation in treatment. The importance of team-work is clearly seen in this service, where social action must be related to medical treatment, and where the infectious nature of the disease and the need for hygiene emphasise the complementary functions of almoner and health visitor. Together, as some of the evidence pointed out, these workers can provide an expert service. Where there is no almoner or other social worker part of the burden of social care falls on health visitors, who are themselves in short supply.

430. All local authorities provide a tuberculosis service under the direction of a chest physician appointed jointly by the regional hospital board and the local health authority. Normally this is based on chest clinics some of which also treat non-tuberculous conditions such as bronchitis, asthma or cancer of the lung. The tradition of voluntary service in the former tuberculosis dispensaries is still active today. Replies to the questionnaire showed that many of the present care committees depend on voluntary effort

and that 31 per cent of local authorities use voluntary organisations in this way. Some committees have been established *ad hoc* but in a few areas they are provided by a rural community council, council of social service or family casework agency. Elsewhere, and particularly in Scotland, the British Red Cross Society provides some services which may include craft teaching or occupational therapy. In London, the London County Council has an arrangement with the Invalid Children's Aid Association to board out children who are tuberculosis contacts. In some areas combined statutory and voluntary effort has built up a comprehensive after-care service as, for example, in Surrey and Buckinghamshire.

431. Before 1948 one of the major functions of the care committees was to provide financial assistance to maintain the families of tuberculous patients during lengthy periods of treatment. Monetary needs can now mainly be met in other ways but financial help from voluntary funds is often still necessary to provide extra nourishment, clothing and household equipment, or to help with travelling expenses to visit relatives in hospital, and so on. Voluntary funds may also supply materials for occupational therapy or meet the cost of correspondence courses. It is usual for almoners or other social workers in this service to act as honorary secretaries to the care committees. In some areas they are also responsible for fund raising. This particular function is a survival of earlier activities, but though good use is made of voluntary funds we are doubtful if raising them should be regarded as a legitimate, or economic, use of a social worker's time. It is certainly inappropriate for professionally trained social workers.

The functions of almoners

432. The staffing position was described in paragraphs 345–348. The questionnaire returns showed that no less than 63 per cent of qualified almoners employed by local health authorities were concentrated in London and the home counties. Of these 73 per cent were employed by English county councils and 23 per cent by English county boroughs. It is therefore exceptional to find a medical social caseworker in the larger urban areas outside Greater London. The range of duties of almoners and of other social workers engaged in the after-care services are discussed in paragraph 345. Forty-five per cent of qualified almoners were engaged solely in work with the tuberculous but it is convenient to consider their functions more generally.

433. The professionally trained almoner is a caseworker in a medical setting, and she is sometimes referred to by her other name of medical social worker for this reason. She assesses the personal, family or social factors relevant to medical diagnosis and treatment, and helps patients to deal with these stresses, and to try to solve problems which may be causing anxiety and strain, or which delay response to medical treatment. She is trained to help people in the acceptance of, or adjustment to, illness or disability and to modify disturbed, emotional or family relationships. In doing this she uses casework skill. She may also provide material help, or assist with practical arrangements for the care or boarding out of children (usually tuberculosis contacts), the confinement of an unmarried mother, convalescence on discharge from hospital, or co-operate in meeting employment or housing needs. All these services are used as part of casework. The almoner has a sound knowledge of the statutory and voluntary services, she co-operates with these and acts as liaison between the individual or family and the agencies which

can help; but her main contribution lies in her understanding of the social implications of, and human reactions to, disease, and in her ability to assist the family or individual to meet their difficulties. Generally, and not only in relation to tuberculosis, her work falls into four inter-related stages —supplying information about the resources available, arranging services or material assistance, giving support through the crisis of diagnosis and illness, and providing casework help.

434. In the tuberculosis service the almoner's sphere may extend into hospital or sanatorium if there is no almoner to deal with social problems arising during in-patient treatment. This continuity of relationship may often be of value if for instance the patient wishes to discharge himself against medical advice, or if lack of occupation during subsequent convalescence or domiciliary treatment leads to family friction or a premature return to work. These difficulties are less likely to arise if the local authority provides an occupational therapy service but young adults living at home often need particular help if they are to persevere with medical treatment. A close association between chest physician and general practitioner, almoner, health visitor and occupational therapist can ensure a comprehensive service. A similar association is desirable in the after-care of other sick persons. The emphasis on the domiciliary care of illness previously treated in hospital, and on the rehabilitation of the handicapped, suggests that in future almoners may be even more necessary in a community setting than in hospitals. This suggestion was put to us more than once in evidence and we fully agree. It is indeed surprising that the scope for medical social work in the local health authority appears to be so little recognised.

435. Social workers without an almoner's training also play a part in chest clinics and in the care of unmarried mothers and the elderly. Some have a social science qualification or experience in dealing with family or individual problems, or they may have previously been employed in some other form of social work. These workers provide material and practical help but they will not usually be sufficiently skilled to deal with the more complex problems where a knowledge of human behaviour, understanding of personal relationships and reactions, and casework skill are required. The questionnaire returns showed that a number of these workers were referred to as almoners, no doubt in some instances because they were filling an almoner's post. We think nonetheless that separate terms should be used in order to avoid confusion about functions.

Social aspects of venereal disease

436. In the questionnaire we asked that officers concerned with venereal disease should be distinguished in the staffing returns so as to obtain an indication of the services provided. Twenty-four per cent of authorities made this distinction, of which the majority were county boroughs in England and Wales, or large burghs in Scotland. These consisted of some, but not all, large cities and concentrated areas of population and also a few predominantly rural counties. Some returns indicated that only contact tracing was undertaken, usually by staff with health visiting or nursing qualifications; five men were employed for this purpose by county boroughs in England and Wales. Eleven health authorities employed almoners or other social workers, a few shared the services of a hospital clinic almoner. The extent to which their functions were combined with other duties is referred to in the previous chapter (paragraph 345).

437. Reference was made in paragraph 213 to some of the effects of recent developments in medical treatment. In the past the help of a social worker was needed with disturbed personal and family relationships, in following up children requiring treatment, and in dealing with the practical difficulties caused by clinic attendance over a long period or in finding suitable accommodation or employment. Nowadays those attending clinics are less likely to be distressed by the diagnosis, or to fear the consequences. They are quickly rendered non-infectious, and may require two, or at most three, attendances to complete medical treatment. It is therefore difficult for an almoner or other social worker to establish contact unless her help is specifically sought. Clearly, prevention must begin much earlier than clinic attendance or referral to the local health authority. The volume of contact tracing has decreased, so that health visitors and other health workers have much less opportunity than hitherto of identifying the young girl or woman in need of help, or the potential prostitute.

438. In these circumstances venereal disease clinics no longer appear to be a significant setting where social workers can assist with personal and social problems concurrently with medical treatment. It seems likely, therefore, that the trend towards reduced specialisation in the work of local health authority almoners in this sphere will continue, and any casework which is possible will normally form part of a general case load.

Social work with families

439. The development by some local health authorities of social work services to assist with a variety of family problems was noted in paragraph 201. There has been a comparable development under the National Assistance Act for families in danger of eviction or in temporary accommodation, to which further reference is made in paragraph 503.

440. Families may require such help for a variety of reasons, a number are mentioned elsewhere in this chapter. Here we consider situations where the needs of the family rather than of individual members are predominant. Social workers in health departments are naturally not alone in attempting to meet these needs but their contribution has been appreciated as greater understanding of family problems has grown. It is only in recent years, for example, that it has been generally accepted that many social problems affect the whole family, and that individual members can rarely be helped effectively without taking the total situation into account. The social complexity of some apparently simple situations has also become clearer. Much earlier, a similar recognition of the relevance of social factors in the treatment of physical and mental illness led to the inclusion of almoners and psychiatric social workers in the medical team. In the same way the social aspects of certain family problems coming to the attention of local health authorities require the help of trained social workers in assisting the family to deal with its own problems and to utilise the resources available. A proportion of families will need more intensive and prolonged help, sometimes continuously over a period. There are also some, usually where there are no bonds of affection between parents or children or there is active cruelty or psycho-pathology, where a break-up of family life may be the only solution. These are the more extreme cases which attract public attention, but we have been impressed by the extent to which families

with many kinds of problems could be constructively helped at an early stage by trained social workers in either health or welfare departments. Our views on this have been confirmed by evidence which shows that families are admitted to temporary accommodation, or application is made to the children's department to receive children into care, at the point of breakdown. Instances of this kind seem to indicate that preventive work was not undertaken in time.

441. Where a family is in danger of breaking up this may sometimes be due to the inadequacy of the mother, or to excessive strain complicated by ill-health. We mentioned (paragraph 201) the recuperative centres for such mothers and their younger children where they may stay for periods of up to 4 months, or sometimes longer. These provide rest and an opportunity of building up the health of both mothers and children. Simple training is given in household management and child care and the mothers are helped to make use of the health and other social services normally available to them in their own homes. Experience shows that the value of the stay, and the extent to which permanent benefit is derived, depends largely on gaining the father's co-operation as part of the planned rehabilitation of the family as a whole. The home must be prepared for the mother's return and there should be immediate and adequate social follow up once the family is reunited. If this is not provided by a worker able to support and encourage the mother in putting into practice what she has learned a fresh deterioration may occur.

442. Some families respond to help in their own homes—the part played by the home help service in this connection is referred to in paragraph 474—or to a visiting social worker. In Hertfordshire, for example, the local authority has appointed a families welfare officer to prevent the break up of families and to seek the co-operation of housing authorities in preventing eviction and admission to temporary accommodation. These arrangements, and also those in Reading, are more fully described in Appendix F. In that authority a family caseworker on the staff of the medical officer of health acts as honorary secretary to the voluntary family aid group formed to prevent the break-up of families and the separation of children from their parents.

443. This is a sphere in which health visitors are also concerned and have much to contribute in raising standards of child care. In some areas they are specifically employed on work with 'problem' families, sometimes in co-operation with the home help service. In one or two authorities they have regular discussions with the psychiatric social worker in the mental health service about the more difficult problems.

444. In seeking to assist the particular group known as 'problem' families local authorities have been much influenced by the work of Family Service Units. The questionnaire returns showed that the 11 units in England and Wales were all used by the appropriate authorities who met between 75 per cent and 100 per cent of the cost. A number of authorities mentioned their desire to promote the setting up of a unit in their area. Seven others had arrangements with a voluntary family casework agency for work with general family problems in addition to 'problem' families. Some authorities are themselves developing a similar type of service and have appointed trained or experienced family caseworkers. In Northumberland, for example, the local health authority has assumed responsibility for a preventive service

(modelled on Family Service Units' methods) originally pioneered by a voluntary family care committee. The experience of this authority confirms what Family Service Units has maintained, that it is often necessary to visit such families every day and to spend much time in dealing with the recurrent crises which characterise their inability to manage their own affairs. This implies that the case loads of social workers undertaking such intensive work must necessarily be small. In one authority included in our inquiries the family caseworkers providing a service of this kind had an average of seven to eight families in their case load. It is therefore important before such intensive and long-term work is attempted to assess the capacity of the family to respond, and this points to the need for early identification. It is also essential, as Family Service Units pointed out in evidence, to consider how far the family background can be sufficiently improved to prevent neglected children becoming neglectful parents in their turn.

445. The need to help these and other families is most easily seen in acute situations, if there is neglect or ill treatment of children, or if the family is likely to break-up for other causes. There is a similar, and perhaps greater, need to recognise the potential problem before it becomes acute, and to provide help to any family known to health or welfare departments which is in difficulties, or where some special need arises. This is not only real preventive work but also sound economic policy, since failure to give effective help in time frequently results in a demand for more costly services.

446. Like almoners and psychiatric social workers, family caseworkers are trained in casework, though they operate in a general rather than a medical or psychiatric setting. These workers are unfortunately rare in health and welfare departments at the present time but their contribution will increasingly be required as the social work services develop.

The mental health service

447. All local authorities undertake the statutory duties laid on them by the Lunacy and Mental Treatment and Mental Deficiency Acts in England and Wales, and, in Scotland, by the Lunacy (Scotland) Acts and Mental Deficiency and Lunacy (Scotland) Acts, but not all provide a community care service. Progress has on the whole been slow and uneven, and relations between local health authorities and hospitals vary considerably. There are some well known, well integrated, local authority and hospital schemes where there is joint use of medical and social work staff, and the hospital helps with the in-service training of mental welfare officers : case conferences are held regularly and a comprehensive after-care service is available. In other parts of the country there is no effective co-operation between the two authorities and the mental hospitals retain an interest in their patients until they are finally resettled. In such areas the local health authority service is almost entirely limited to carrying out the statutory functions of certification and removal of the mentally ill, and the ascertainment and supervision of mental defectives.

448. There are many gradations between these extremes. Even if an authority is anxious to develop a community care service it may be unable to do so owing to shortage of suitably qualified staff, or restrictions on expenditure. This is particularly unfortunate at a time when there is

increasing recognition of the value of social services for the mentally disordered, and an emphasis on prevention and care in the community rather than removal to hospital. The public is becoming more aware that mental illness is widespread and also of the possibilities of modern treatment and rehabilitation. The mentally ill are now known to require help with their personal problems, with family and social relationships, and with employment. It is known too that adequate assistance of this kind may prevent breakdown or aid recovery. This awareness is demonstrated by inquiries received by some local authority services for help, either for the inquirer or a relative. It is therefore a matter of real urgency, as the Royal Commission on the Law relating to Mental Illness and Mental Deficiency has pointed out, to expand and develop the facilities in the community.

449. We have not found it possible to estimate the numbers likely to require care by the local health authority since it is not until provision is made that these numbers can be known. When an effective service is available experience shows that hospitals usually refer a high proportion of discharges to the medical officer of health. Similarly general practitioners may refer patients where there is a possibility of preventing mental breakdown, or it is felt that social work either with or without psychiatric treatment may be required. In areas where the local authority service is not well developed, or it has not been possible to secure trained staff, hospitals and general practitioners are often reluctant to refer their patients as there is no assurance that they will be visited by an appropriate worker. The statistics given in paragraphs 233 to 237 suggest that even allowing for all these variations a large proportion of the mentally ill will ultimately reach the notice of the local authority.

450. The mental health service has thus an increasing importance in the community and must play an appropriate part, both in prevention and after-care of mental disorder and in assisting with other social problems, such as absenteeism in industry, the voluntarily unemployed, delinquency and marital or family difficulties of various kinds. Some older people, for example, become mentally confused yet do not require admission to a mental hospital, and might be helped by social workers from the mental health service to live satisfactorily in their own homes. In one area elderly people referred to the mental health service are visited jointly by the hospital psychiatrist and the mental welfare officer to decide on the appropriate type of care. Admission to a mental hospital can often be avoided in this way. Developments such as these are to be welcomed, provided adequate support is available to the family.

451. The pattern of administration by mental health sub-committees is described in Appendix D. In a few instances these committees also administer other services. In one authority, for example, the sub-committee deals with mental health, tuberculosis, and the general after-care of cripples and paraplegics, in another with mental health, the nursing services and prevention, care and after-care in general. One county borough administers the mental health service and those for the blind and general classes through a handicapped persons sub-committee.

452. Decentralisation in counties is apt to follow the characteristic staffing pattern already noted (paragraph 328). In these authorities district welfare officers in services under the National Assistance Act also act as duly

authorised officers or as mental welfare officers, whether the health and welfare departments are separately administered or not. One reason for this is the smaller demand for an emergency service in rural districts. In one area some of these officers with combined functions had no more than 8 to 10 certification cases a year in contrast to their colleagues in the urban areas where there might be several hundred in the same period. This combination of function is discussed further in paragraph 645. The arrangements in Scottish counties where the same officer is frequently employed as authorised officer, welfare officer and district council clerk were mentioned in paragraph 410. It is also common practice for welfare officers in Scottish large burghs to have mental health functions. In all three countries some health visitors undertake certain mental health duties, usually the visiting of mental defectives.

453. In the questionnaire we asked for details of the use of voluntary organisations in the care of the mentally disordered. Replies showed that most authorities use appropriate voluntary organisations where these exist, but the country is not well covered in this respect. About 5 per cent of authorities have agency agreements of one kind or another with a voluntary body, mainly for the care of mental defectives, usually in providing voluntary help at occupation centres or undertaking guardianship or voluntary supervision. They also help with arrangements for short-term care, and for holiday or recreational facilities. Some reference was made in the replies to provision for the after-care of the mentally ill and to the value of therapeutic social clubs, some of which are provided by voluntary organisations for ex-patients of mental hospitals.

454. Occupation centres play an essential part in the training and occupation of mentally defective children and adolescents. Similar centres for adults with an emphasis on industrial occupation are now provided in some areas. We noted (paragraph 353) that a small number of authorities gave details of the supervisory staff of occupation centres in their replies to the questionnaire. Most of these were regarded as having a social work function subsidiary to their main employment, and some returns showed that they also undertook home visiting. We agree that there is a social element in this work but in view of their predominantly teaching functions we have regarded staff of occupation centres as outside our terms of reference.

455. The recommendations of the Royal Commission on the Law relating to Mental Illness and Mental Deficiency in England and Wales, and comparable reports on the Scottish mental health services open new possibilities of residential care for the mentally ill and defective in the community. The Royal Commission took the view that in England and Wales any provision of residential care by the health department should not exclude mentally infirm or handicapped persons from similar care under the National Assistance Act, particularly elderly persons suitable for an ordinary old people's home. It is likely therefore that residential accommodation for the mentally ill or defective may in future be provided by either health or welfare departments[1]. What is abundantly clear is that a considerable residential service will be required. It should be staffed by officers with a real understanding of the needs of the mentally disordered, and supported by a well developed community care service.

[1] Legislative effect will be given to this if the Mental Health Bill, now before Parliament, becomes law.

The functions of duly authorised, authorised and mental welfare officers

456. The staffing of the mental health services was described in the previous chapter. We referred (paragraph 219) to the variations in present nomenclature and to our use of the term 'mental welfare officer' to denote officers who undertake work with the mentally ill and defective except when we wished to distinguish between the duties of certain workers, or between specific services. For convenience we consider separately the functions of duly authorised, authorised and mental welfare officers.

457. Prior to 1948 mental health, or mental welfare, officers were concerned wholly with the care of mental defectives. When the National Health Service Acts came into operation in 1948 many former Poor Law relieving officers joined the local health authorities and were designated either as duly authorised or authorised officers or as mental welfare officers. At the same time their function of ensuring the admission to hospital of persons of unsound mind remained virtually unchanged. In the development of the service since 1948 the designation 'mental welfare officer' has come to have a wider meaning. These officers may be concerned with the care and after-care of the mentally defective and the mentally ill, and also authorised to take the initial steps for admission to hospital, or they may undertake only one of these activities.

458. In some authorities duties in connection with certification and removal are on a rota system and the duty officer for the day takes all emergencies. Usually a 24-hour service is provided. Generally speaking, duly authorised officers are engaged solely in statutory duties in the larger cities and some of the larger counties in England and Wales. Local authorities are required to appoint officers 'duly authorised' to carry out the legal procedures in the mental health service, and there is therefore a statutory obligation to fill vacancies. There is no obligation to appoint any particular type of officer.

459. At present, under compulsory procedures, duly authorised and authorised officers co-operate with general practitioners and psychiatrists and with magistrates or sheriffs in arranging for certification. They also secure the hospital vacancy. In England and Wales, they accompany the patient to hospital and hand over the necessary documents: in Scotland, this duty is undertaken by the ambulance service. In England and Wales, but not in Scotland, they have power under Section 20 of the Lunacy Act, 1890, to authorise compulsory removal to certain hospitals without a medical certificate. When admission is arranged in this way, the duly authorised officer must satisfy himself that the person concerned should be placed under care and control, and he is thus obliged, unlike other officers within our terms of reference, to take decisions affecting the liberty of the subject.

460. Some of the main recommendations of the Royal Commission relate to certification procedures in England and Wales. If these are implemented, duly authorised officers will no longer have power to authorise compulsory removal on their own but will, in an emergency, require one medical recommendation instead of the two which the Royal Commission recommended should normally be required.[1] They would still have responsibility for removal, and for obtaining a hospital vacancy, and would therefore continue to play an important part in the admission to hospital of the mentally ill.

[1] Legislative effect will be given to this recommendation if the Mental Health Bill, now before Parliament, becomes law.

461. The work of duly authorised officers calls for sound judgment and may often involve considerable strain and urgent action. They are faced with difficult decisions and should have supporting psychiatric consultation and casework help. If they are called in during an emergency but find no grounds for statutory action they may have to leave the mentally ill person and the family to face their difficulties without social help unless there is a community care service. The lack of comprehensive services is acutely felt in such circumstances, and also when a discharged patient who, with help, might have remained in the community deteriorates to the point that readmission to hospital must be arranged.

462. In many authorities after-care is provided by mental welfare officers, and there are no psychiatric social workers. Where there is a joint use of staff with the mental hospital this helps to compensate for lack of trained staff in the local authority, because the mental hospital psychiatrist or psychiatric social worker can also be available to local health authority staff. Such arrangements also help to ensure continuity of care.

463. In the mental deficiency service the mental welfare officer may be responsible for collecting information in connection with ascertainment, or act as petitioning officer to obtain a magistrate's order to admit a defective to hospital. In some areas he reports on the home conditions of defectives considered ready for discharge from hospital or whose relatives have applied for release on licence. In England and Wales a defective under guardianship or statutory supervision must at present be seen periodically.[1] Voluntary supervision of those not subject to be dealt with is provided at the request of the person concerned or more usually of a near relative. The mental welfare officer arranges this, and secures the provision of training or occupation. He offers help in finding suitable employment, and may also be concerned with arrangements for short-term care or otherwise assisting a family in a crisis. He co-operates with the family, which may itself require help with emotional problems which result from having a mentally handicapped member. Since mental deficiency is a chronic condition the mental welfare officer will often know an individual or a family over many years, perhaps for a life time.

The functions of psychiatric social workers

464. While the mental welfare officer can assist some mentally ill persons, others require the help of a psychiatric social worker. The majority of these officers employed by local authorities work in child guidance clinics, and excluding those shared with hospitals only 31 are at present in health departments. A few social workers with a social science qualification but without a mental health training are also employed. In contrast to almoners, qualified psychiatric social workers are more evenly distributed between counties and county boroughs in England (there are 2 in Scotland and 2 in Wales) and less concentrated in London and the home counties. To a large extent they are still doing pioneer work. The evidence suggests that they are often only able to meet the most pressing and obvious needs and consequently many people who might have benefited from casework help cannot be accepted. The main source of referral is usually the mental hospital within whose catchment area the authority is situated, but general practitioners, health

[1] The Mental Health Bill, now before Parliament, provides for statutory supervision to be replaced by a general responsibility to provide care and appropriate services.

workers including health visitors, and social agencies also refer mental health problems. Practical help with employment or other material assistance may be needed as part of casework but generally speaking psychiatric social workers are primarily concerned with disturbed personal or family relationships, and in helping the mentally ill to seek treatment.

465. Psychiatric social workers are caseworkers in a psychiatric setting. As well as learning to make full use of the social services, they study the factors in personality development and human relations and this enables them to recognise and understand deviations from the normal. Their training in the social aspects of mental illness also enables them to contribute to diagnosis and treatment, and in this way they work with psychiatrists. Psychiatric social workers base their work on a study of the history of the mentally ill person, particularly of his personal problems and attitudes, and see him as a person reacting to his environment in which his family will play a prominent part. Their understanding of the nature and variations of mental illness, and what these mean to the family enable them to give appropriate help to disturbed or mentally ill persons and their relatives.

466. In helping the mentally ill and their families to modify their attitudes psychiatric social workers work with the patient towards a more objective view of the situation. One of their functions is to overcome difficulties in making contact with a disturbed person who may be suspicious, hostile or apathetic, and show disturbances of thought or emotion. They establish mutual confidence with their clients where possible and use a professional relationship in a disciplined way to carry out the aims of psychiatric treatment. In co-operation with psychiatrists and mental welfare officers they can often help to prevent the need for admission to hospital, assist in recovery and prevent recurrence of breakdown.

467. Although their primary function is to undertake intensive casework psychiatric social workers may also act as consultants, working through other workers if this is appropriate. This particular function enables them to advise on related problems which may have a mental health aspect.

468. In a clinical setting psychiatric social workers work in consultation with and under the direction of a psychiatrist. In the local authority they may be able to consult a psychiatrist either on the staff of the medical officer of health or in a mental hospital. The possibilities of psychiatric consultation are particularly important when an emotionally disturbed person is not receiving psychiatric treatment.

469. As with almoners the questionnaire replies showed that social workers without a mental health training were sometimes referred to as psychiatric social workers. The Committee on Social Workers in the Mental Health Services recommended that this term should be restricted to persons holding a university mental health certificate, and this is also our view.

THE HOME HELP SERVICE

470. The home help service in its present form is one of the newer services established in 1948. At first conceived as an ancillary to the local health authority services for mothers and young children, the sick and mentally disordered, it has come to play an increasingly important part in the domiciliary care of the elderly, in social work with families, and in assisting a wide

range of people for whom other local authority services are provided. This evolution is illustrated by the change in use since 1948, and varied developments within the service. Originally the main demand was for maternity work, but it has recently been estimated that between 70 per cent and 80 per cent of the service is devoted to the elderly, and about 10 per cent to 15 per cent to families with social rather than medical problems, that is, in homes where the standards of living or child care are low, in preventing the break-up of families and in work with the 'problem' family. There is an increasing emphasis in this side of the work in some areas, and on home making, resident helps and 'sitters-in', but expansion is sometimes limited owing to financial restrictions.

471. The service may often be a decisive factor in enabling older people to remain in their own homes, and many authorities now make special provision for the elderly. Usually three distinct types of service are required, occasional but regular help to prevent deterioration, continuous assistance for the bedridden and those unable to leave their beds without help, and work with those who are so neglected as to be living in a state of mental and physical deterioration. The organisers whom we met all emphasised the necessity in the care of the elderly for close co-operation between workers in related services, including the voluntary services. Some organisers find it helpful to be members of the local old people's welfare committee, as for example in Rotherham where a meals service is provided by the home help service jointly with the local voluntary committee. This authority also provides a laundry service for the elderly as part of the home help service.

472. In the authorities included in our inquiries the proportion of the service used by older people varied from 50 per cent to 90 per cent. The larger authorities estimated 30 per cent to 35 per cent for the chronic sick. There has been some development of night attendance for the sick to enable relatives to rest but experience has varied. We were told by one authority that there was little demand for these facilities and by another that the service (which was administered separately from the home help service by the superintendent of home nurses) was much used, about 50 per cent for the dying and nearly 25 per cent for those waiting admission to hospital.

473. Maternity and emergency cases always receive priority but are noted for difficulties of organisation. Most authorities make special arrangements for tuberculous households by selecting or inviting volunteers from among helps who have no young children. Generally speaking the service appears to be more used in the care of mental defectives than of the mentally ill. We received some evidence that charges may sometimes be assessed in such a way as to prevent help being given on a long-term basis, as for example to a widower with young children who is unable to make any other satisfactory arrangements.

474. The evidence we received, and the replies to the joint circular of 1956[1], show that the importance of this service in assisting a variety of family problems is increasingly recognised. In London, for example, a special service was started in 1955 for families in danger of breaking up and for

[1] Home Office Circular 118/56, Ministry of Health Circular 16/56, Ministry of Education Circular 311/56.

'problem' families. The home help is usually full-time at first, gradually decreasing her hours as the family situation improves or as the mother learns to manage her household. In Leicester it was estimated that in one year close co-operation between the home help service and the children's department prevented over 1,500 children being received into temporary care under the Children Act, 1948. There has been a similar experience in Kent where a family help service (administered as a separate section of the home help service) provides a 'mother substitute' for a limited period at the request of the children's officer, when this will prevent the receiving of children into care. The children's officer, referring to this service in the reply to the joint circular, considered it to be one of the most effective means of assisting families in difficulties in their own homes.

475. These various schemes, which illustrate the scope of a well developed service, are of particular interest in showing that local authorities can themselves pioneer and experiment within the framework of statutory powers. Generally speaking this is a direct local authority service but in a few areas, as for instance in Exeter, a voluntary organisation provides a complementary service, usually for older people. Replies to the questionnaire also showed that about 6 per cent of English authorities, mainly in the southern half of the country, use the Women's Voluntary Services (which helped to pioneer the service in its present form) either on an agency basis, or in co-operation with an organiser or home helps appointed by the authority.

476. Like the mental health service, the home help service is often separately administered from other health services; so far as we are aware there are as yet no examples of the organiser working from a health centre, as suggested in the Central Health Services Council Report referred to in paragraph 187. In counties the service is often decentralised, and divisional or district organisers are responsible for day-to-day work, and sometimes also for recruitment. In predominantly rural areas centrally based organisers may divide the work between them. In some areas where the superintendent health visitor is responsible centrally, health visitors are usually responsible locally, but occasionally local health visitors work to a county organiser who is not a nursing officer, or the local organiser works to a superintendent health visitor. In some Scottish, and a very few English and Welsh counties, welfare officers acted also as home help organisers (paragraph 350), and undertook recruitment and assessment and collection of charges. In county boroughs in England and Wales, and in large burghs in Scotland, the service is mainly centralised.

477. We heard a variety of opinion about the problems of organisation in rural areas; some witnesses considered it was more difficult to give a flexible service, others thought that more actual or potential help was obtainable from relatives or neighbours. It was suggested that rural areas made less demand than industrial districts, for this reason. In one industrial area, however, the families on a new housing estate built close to the older area were said to be less dependent on the service because relatives were within easy reach and could aid them in difficulties. The strength of family ties and the proximity of relatives probably has a considerable influence on the demand for this service.

The function of home help organisers

478. The staffing position has been described in the previous chapter (paragraph 350). The questionnaire returns showed a high proportion of married women in this service, no doubt because their experience in running a home and bringing up a family is particularly useful. Much of the evidence stressed the need for maturity in this work and considered it unsuitable for younger people, partly because the home helps are often older women with considerable domestic experience. We were told of the pride which the helps take in their work (one authority had a waiting list of prospective helps) and we also heard widespread tribute to the high standard of service, to extra kindnesses, and sometimes devoted care bestowed upon elderly, handicapped or ill people. One field study noted the *esprit de corps* which was generated by the concept of a service much broader than simply giving domestic help.

479. The social work content of this service is high, and there was general agreement about the number of social problems uncovered. The nature of the work requires the home help to spend a longer time in the home than is usually possible for a visiting social worker. She sees the family situation from a different angle and may consequently have a substantial influence upon it. In the normal course of her duties she becomes aware of the material needs of elderly people, for supplementary financial assistance for example, or aids to sight or hearing, or for the adaptation of home equipment to a physical handicap. If she is an understanding and compassionate person she may receive confidences, or perceive tensions or difficulties in a situation requiring more skilled help. Still keeping her own role within the household, the home help can encourage the individual or family to accept and use material help or the assistance of a social worker.

480. In family situations where her role is to support a sick or inadequate mother, or to provide a 'mother substitute' the home help may have a function, which she should clearly understand, of acting as a buffer for tensions arising during a crisis. In these situations she needs the guidance and support of a social worker to help her to understand what is happening, and to encourage a sympathetic but detached attitude, not identifying herself with any one member of the family against another.

481. The relationship between home help and organiser is, therefore, fundamental. This was emphasised by all our witnesses with experience in this field. It was agreed that much of the organiser's time must be given to seeing the helps and discussing their cases, especially those presenting difficulty. The way in which this relationship develops often reflects the personality or interests of individual organisers. One may rely on the written word in the form of newsletters and notices, or encourage a group spirit by having regular group meetings. Another will spend time listening to the home helps' difficulties and will aim at cultivating a particularly friendly and helpful relationship. A third may give practical help by tackling particularly unpleasant cleaning jobs with the helps, and generally being ready to lend a hand whenever this may be required.

482. The organiser's own work contains three distinct elements ; planning and organising the service, social work, and liaison with other services. Planning and organising includes home visiting to assess need and the relative

priority of each application; the recruitment, training and supervision of the helps; record and time-keeping; and frequently, financial assessment of those receiving the service. We were told that in some areas the turnover of staff was high because of the percentage of married women employed, so that much time had to be spent in recruitment, and on working in new officers. Some organisers arrange short training courses, in one instance in co-operation with the education department. Some of our witnesses regarded an organiser's function as mainly administrative, and as resolving the conflicting demands for the service and preventing abuse. Others saw it as containing a substantial social work element, for which a training in social work was desirable. It was generally agreed that a good understanding of social work was necessary in order to work effectively with other social workers, as for example a child care or probation officer. Some understanding of illness was also desirable; close co-operation with health visitors was particularly desirable in the care of the sick and elderly.

483. These varying views on the social work content of the service, and on the functions of home help organisers seem to show that the service itself is still at the experimental stage. In some authorities it has developed into a social work service of considerable significance but this has not occurred in all areas as yet. Whatever the ultimate development it must clearly continue, in addition to its traditional role in the maternity service, to be a major element in the care of the elderly and chronic sick at home and in social work with families.

SERVICES PROVIDED UNDER THE NATIONAL ASSISTANCE ACT

THE CARE OF THE ELDERLY

Domiciliary services

484. An ageing population, which includes many who are also infirm or handicapped, must be expected to make increasing demands on the statutory and voluntary domiciliary services. In paragraph 248 we drew attention to the powers under the National Health Service and National Assistance Acts which make certain provision for the care of the elderly in their own homes or in residential care. We have mentioned the part played by the home help service. Health visitors also have important functions in the care of the elderly in their own homes; we discuss liaison with these and other statutory workers in this field in Chapter 10.

485. It has been estimated that about 95 per cent of men and women of pensionable age live in their own homes or are otherwise cared for in the community. Many are active and well and do not require help from either the statutory or voluntary services. Others with increasing age, infirmity or ill health need medical care or hospital treatment and in addition a variety of supporting services in the home. Many of the activities of the voluntary organisations provide such help. These include regular friendly visiting and help in the home, meals service, chiropody and laundry schemes, clubs providing social or occupational activities of various kinds, holidays and arrangements for short-term care to relieve relatives. Replies to the questionnaire

showed that 83 per cent of authorities co-operate with voluntary organisations in providing such services. The organisations concerned are mainly the old people's welfare committees, the British Red Cross Society, and the Women's Voluntary Services. Councils of social service and rural community councils are also active in this field. In some country districts, women's institutes have appointed members as 'friends' to old people living alone, an arrangement particularly suitable in rural areas.

486. Recently there have been new developments in the voluntary services in various forms of day care, that is in clubs or other centres where the elderly can have a mid-day meal and spend the best part of the day, thus mitigating loneliness and a sense of isolation. Recently also interest has been aroused by experimental 'boarding out' schemes. These are perhaps more aptly described as schemes for finding lodgings since the person concerned is responsible for payment, often with the help of the National Assistance Board. The voluntary organisation brings together someone requiring a home and the family willing to offer it, and keeps in touch subsequently to ensure that the arrangement is satisfactory. A few local authorities have made similar arrangements when an elderly person applying for admission is found not to need residential care. Individual arrangements of this kind can have many advantages but there will always be difficulties and dangers of abuse unless they are accompanied by skilled social supervision.

487. In the care of the elderly, as with others with whom we are concerned, many different workers and services will often be required, and the necessity for co-ordination of effort is generally recognised. A few authorities have established co-ordinating committees for this purpose (see paragraph 1070). Old people's welfare committees fulfil a similar valuable function. In many authorities the welfare department acts as a channel for the exchange of information, and chief welfare officers or other senior officers serve in an honorary capacity on the voluntary committees. At local level field workers also play a part. We heard of one authority where district welfare officers paid regular visits to the clubs for old people provided by the voluntary services to see whether help from a statutory service was required, and to answer questions from club members. The work of welfare officers under the National Assistance Act in the domiciliary field arises from their responsibilities in receiving applications for admission to residential care and in connection with grants to voluntary organisations. They co-operate with appropriate domiciliary services and ensure that these are provided if a suitable vacancy is not immediately available. In some health departments, as we have seen, almoners or other social workers in the after-care service undertake work with the elderly awaiting admission to, or discharge from, geriatric units. A few work closely with the geriatrician with whom they may pay joint domiciliary visits. These visits have been found valuable in gaining the family's co-operation and in ensuring willingness to resume care of an older relative on discharge from hospital. There is scope for further development on these lines. The problems of providing adequate care of the elderly in their own homes within manpower and financial limitations are not easily solved. It is clear that the emphasis must be on early discovery of need and on concerted action in making the best use of the resources available.

Residential accommodation

488. Residential care[1] under the National Assistance Act provides for a wide range of elderly, infirm, mentally or physically handicapped adults of all ages who are otherwise unable to obtain the care and attention they require. The great majority are over pensionable age, but it is apt to be overlooked that some younger people also require similar care.

489. Admission to residential care is a major event in the life of the individual concerned, regardless of age. Where an independent existence has become increasingly hazardous the change may be welcomed with relief, but whatever the reason, or the outlook for the future, giving up a home and possessions or an independent life is usually a painful experience. This is especially true of the elderly, for whom a severing with the past (at a time in life when it is less easy to adjust to new conditions) may lead to some disorientation and difficulty in settling down. One organisation, whose evidence related to another sphere of the health and welfare services, suggested that arranging admission was purely an administrative matter. In fact considerable skill may be required of the social worker as many personal and practical difficulties can arise. There must also be effective co-operation with workers in other services which may previously have been involved.

490. In making plans for this service in 1948 the majority of authorities aimed at gradually closing the large and obsolete Poor Law institutions, and replacing them by small homes in which the residents might lead a more homely life. A great deal has been achieved on these lines in the last ten years, but restrictions on capital expenditure, shortages of various kinds, an ageing population and the increasing infirmity of those requiring care have resulted in the continued use of some premises for longer than was foreseen. There are still waiting lists in many areas. It is significant however, and in keeping with comparable experience in other health and welfare services, that the way in which authorities have responded to changing concepts of statutory care has affected the use of the service. It is now common experience for the opening of a new small home to result in an increased demand for accommodation in the surrounding neighbourhood. Though the stigma of the Poor Law institution is still not a thing of the past it is certainly passing. Some of our witnesses who work in this field suggested that the change was more rapid than could have been foreseen ten years ago.

491. One of the worst features of the old mixed institutions was the extent to which younger mentally or physically handicapped persons and unmarried mothers were admitted, often to remain for the rest of their lives. Since 1948 many authorities have taken pains to prevent this, usually by arranging admission to a suitable voluntary home, though such facilities are still somewhat limited. For many years some authorities have provided homes for the blind in addition to making use of similar provision by voluntary organisations. Homes for the deaf, and for those with various physical handicaps, are almost exclusively provided by voluntary organisations, mainly because of the small numbers requiring such care in any given area. As a result handicapped people are admitted to voluntary homes or epileptic colonies which may be a considerable distance from their own locality,

[1] This term is preferred to the more commonly used Part III Accommodation, i.e., accommodation provided under Part III of the National Assistance Act.

thereby increasing their general isolation from the community. We were glad to know that some voluntary organisations and also a few authorities are planning new accommodation for certain groups, sometimes in collaboration with neighbouring authorities, as for example in Yorkshire where Leeds has established a new epileptic colony on behalf of a number of authorities. As the Committee on the Rehabilitation, Training and Resettlement of Disabled Persons (the Piercy Committee) noted, there is much scope for experiment in providing residential care for the handicapped and also in short stay hostels or other short-term care.[1] We agree with that Committee that many families, and in particular mothers or wives, would be better able to stand the strain of caring for a severely handicapped person if these facilities were more readily available.

The functions of residential staff

492. The immediate responsibility of promoting a homely way of life in communal surroundings rests mainly on the matron or warden. The care provided in many local authority homes during the last ten years has emphasised the individuality of the residents, their freedom to come and go, to preserve or make fresh links with the community and, as far as possible, to take a share in the running of the home. Much credit is due to authorities and their staff for these achievements, particularly in some of the former institutions where the problems are harder to solve. The home making qualities of senior residential staff and their understanding of human relationships are of vital importance, as many authorities have recognised by welcoming the pioneer training and refresher courses organised by the National Old Peoples' Welfare Council and the Scottish Old Peoples' Welfare Committee. At the outset of our inquiry some doubts were expressed to us as to whether residential staff came within our terms of reference. It is clear to us that in certain respects residential work with the elderly, with homeless families, and with unmarried mothers and the handicapped contains a social work element. In the questionnaire we suggested that some residential staff might be included in the returns if desired. Details of these officers have been noted (paragraph 351).

493. A few authorities have appointed an officer to visit residents in large homes (particularly the former institutions) and also, in some areas to keep in touch with those admitted to hospital. These workers, usually women, discuss personal problems or difficulties with the residents and if possible help them to find solutions. There is scope for these arrangements, which assist senior residential staff in addition to bringing a personal element into communal life, especially when the size of the home and administrative duties make it difficult for the warden or matron to spend as much time with individual residents as they themselves would wish.

The functions of welfare officers

494. The care of the elderly and the homeless provides a convenient place to consider the work of welfare officers, but it is not easy to describe their multifarious duties. These officers constitute the largest group of workers within our terms of reference. We have noted (paragraph 327) that more than 50 per cent have functions in the mental health or mental deficiency services in addition to responsibilities under the National Assistance Act. This applies particularly in Scotland, and in English and Welsh counties. They

[1] Cmd. 9883, paragraphs 119–120.

may also be responsible, as already mentioned (paragraph 476) for organising the home help service, or be concerned with the care of unmarried mothers. Information regarding the administrative responsibilities of chief welfare and deputy chief welfare officers is given in Appendix D. Details of these officers have been given in the previous chapter (paragraphs 322 to 325), where reference is also made to other administrative officers whose work contains a social work element (paragraphs 334 to 335). In the following paragraphs, we outline the functions of welfare officers who are mainly field workers, though in some areas, and especially in the smaller authorities, some duties may be undertaken by administrative or senior officers.

495. Under the National Assistance Act welfare officers receive and investigate applications for admission to residential care and may also keep or review the waiting lists and maintain liaison with general practitioners and hospitals. In co-operation with general practitioners, health department workers and officers of voluntary organisations, they assist in the care of old people in their own homes and may thus prevent or postpone the need for admission to residential care. They also arrange accommodation for families who are temporarily homeless when no other solution can be found. In some areas (as noted in paragraphs 503 to 505) they keep in touch with housing authorities in trying to prevent eviction or in re-establishing families who have lost their homes in this and other ways. Welfare officers are frequently concerned with the services for the general classes of handicapped persons, often in co-operation with occupational therapists and craft instructors : in a few authorities they also provide services for the blind and deaf. In addition they may have a range of miscellaneous duties including the collection of payments of various kinds, the temporary protection of property of persons admitted to hospital, registration of births, deaths and marriages, and civil defence, and (in co-operation with the health department) the compulsory removal of sick or aged persons under Section 47 of the National Assistance Act.

496. The widest range of functions is found in Scottish counties where (as noted in paragraph 410), the post of district welfare officer and district council clerk is frequently combined ; these duties may also include functions under the Education and Children Acts. In the islands and sparsely populated counties the district welfare officer may sometimes be the sole representative of several authorities including the National Assistance Board, the Ministry of Pensions and National Insurance and the Regional Hospital Board. Details of the grouping of functions in Scotland, and elsewhere have been given in paragraphs 327 to 328, and are discussed further (paragraphs 668 to 670) in relation to the 'general purpose social worker' in our terms of reference.

497. Much of the evidence referred to the key position held by district welfare officers, not only in relation to the health and welfare services but in co-ordinating the relevant statutory and voluntary services at field level. There was general agreement in the local authority evidence that many undertook work of a non-statutory nature, often meeting residual or other needs not covered by a statutory service. One of the field investigators described this.

> "The most striking factor about the activities of the district welfare officer/mental health officer is the amount of work attracted to him other than that under the statutory services. Perhaps because the title 'district welfare officer' is general

not specific (as compared with children's visiting officer, probation officer, health visitor, etc.), perhaps because a sense of responsibility precludes the officer from refusing to help even though it is not strictly in his province, general practitioners, local medical officers, social and welfare officers, as well as the general public call on him for help in many situations. . . . The district welfare officers are well known in person and not only by office in their respective districts. Most of them have been familiar figures in the neighbourhood for many years, first as relieving officers and now as welfare officers. They are turned to by a wide variety of workers for help and opinion. In most areas they are well known to general practitioners and the latter appear to ask them for help with social problems rather than other more specialised workers. This may be because the general practitioner is likely to know the district welfare officer personally in carrying out his responsibilities for the removal of a mentally ill patient."

TEMPORARY ACCOMMODATION

498. Temporary accommodation under the National Assistance Act was originally designed as an emergency measure to meet the demand for immediate shelter following fire, flood, or similar catastrophe. It has proved in practice to have been required mainly by families homeless for quite different reasons, having to leave furnished lodgings or tied cottages, for example, or turned out after quarrels with relatives, or through eviction for overcrowding or non-payment of rent. The incomplete family, that is, deserted, unmarried, or otherwise unsupported mothers and their children also find their way into temporary care.

499. Families who are homeless for these and other reasons are not a new phenomenon, but they came into startling prominence with the advent of the new service and the shortage of housing after the war. Under the Poor Law, families in similar difficulties had in fact the same alternatives as now of either managing for themselves, or, in the last resort, applying to the local authority. Managing for themselves usually meant sharing with friends or relatives or finding fresh accommodation, frequently of a poorer type than before, and often in slum property. Applying to the local authority implied destitution, and admission to a public assistance institution where the family was separated, the children going to the nursery or children's home, the mother to the women's side and the father, if admitted at all, segregated in the men's accommodation. Unmarried mothers fared particularly badly in these circumstances and were often quite unable to re-establish themselves or their children in the community again. Families with both parents had the best chance of getting a fresh home if the father was in work and anxious and able to re-unite his family. But if this incentive was lacking, and the mother was similarly unable or disinclined to set about home-making, the break-up of a family in this way often became permanent. The same social problem in a slightly different form existed then as now, though often unrecognised by those administering the service.

500. During the first few years after 1948 many local authorities were overwhelmed by the sheer numbers for whom accommodation had to be provided, the difficulty of re-establishing many of the families in the community during an acute housing shortage and the complexity of the social problems which came to light, some without precedent in the experience of local government officers. It was not perhaps surprising, so near to the Poor Law era, that at first the majority of authorities refused to admit fathers with their families, and that there was a tendency to provide communal facilities, or, in some

cases, separate arrangements for younger and older children. Much of the actual accommodation had perforce to be provided in former Poor Law institutions which were structurally unsuited to family life.

501. It has always been difficult to make a valid assessment of the size of this problem, which has presented local authorities with difficulties out of all proportion to the numbers involved, or to analyse the factors in individual cases which, if recognised in time, might have prevented the need for admission. The figures published by the Ministry of Health relate to one night of the year and give only an indication of the position at any other time. The peak figure recorded was on 1st January, 1951, when 6,060 persons including children were in temporary accommodation. On 31st December, 1957, the figure was 4,469 of which 1,649 were adults (men 393, women 1,256) and 2,820 children. The main burden of providing this type of care throughout the years has fallen on the larger authorities. In Scotland the published figures relate to a full year. During the year ended 30th June, 1957, 272 adults accompanied by 490 children were admitted to temporary accommodation.

502. Not all families admitted to temporary accommodation also need help from a social worker, and this increases the difficulty of estimating the number requiring such help. The majority make only a temporary stay and find accommodation for themselves, or are helped to do so. Others make up quarrels with husbands or relatives and return whence they came. The remainder usually present a variety of difficult problems and the mobilisation of wider social resources on their behalf has been slow. With experience, and increased understanding of the help required, efforts have gradually been made by a number of authorities to preserve the family unit, and to foster a sense of parental responsibility. Some have been able to provide accommodation away from the former Poor Law institutions, sometimes with a resident warden in charge. Here the father can usually join his family and the danger of break-up is reduced. Residential staff can, and frequently do, play an important part in helping these families to become acceptable tenants and in aiding their resettlement in the community.

503. A very few authorities have set up residential units for families presenting particularly difficult problems and have selected residential or other staff to give practical guidance and supervision. Others have called upon the help of voluntary organisations, either to provide home advice groups in which the mother can learn simple domestic practices, or to undertake intensive casework while the family is still in temporary care. An increasing number have sought the co-operation of housing authorities in identifying tenants in danger of eviction, so that preventive action can be taken or arrangements made for intermediate housing if the home has already been lost. The arrangements in Hertfordshire were mentioned in paragraph 442. Another example involving the joint use of staff by two departments is seen in Derbyshire where the services of the warden and matron of the temporary accommodation are shared by the welfare and children's services. These officers work with the mothers and try so far as their time allows to follow up the families on discharge to prevent rent arrears in the new home. In Birmingham, psychiatric social workers in the mental health service advise the housing department on the action to be taken with selected families in danger of eviction through arrears of rent.

504. In Liverpool the health department secured the co-operation of the Liverpool Personal Service Society in undertaking casework with families whose stay in temporary accommodation was no longer temporary. The aim was first to rehouse the families and then to keep in touch with them for as long as necessary to prevent the recurrence of a similar crisis. Out of this work has grown a liaison sub-committee, representative of the health committee (which also deals with the welfare services) and other local authority departments, voluntary organisations, a hospital management committee and the National Assistance Board, to co-ordinate work for the rehabilitation of homeless families. The Liverpool Personal Service Society were good enough to prepare a note for our information of their experience in providing this service. This showed the wide variation in the living standards of those admitted, and in the degree of help required. In the Society's view the crisis of admission to temporary accommodation could be a turning point for the better in the family fortunes, but intensive casework was often needed to enable the family to remain united throughout the shock of losing the home and during (in some cases) the temporary separation of fathers and children over 16 from the mothers and younger children. In London the residential units established by the London County Council for the rehabilitation of families unacceptable to housing authorities provide furnished accommodation for small groups of families, including the father. The family is helped as a whole in surroundings where a normal home life can be carried on under the supervision and influence of the wardens, and the scheme has generally proved successful.

505. We were told that in Hampshire the demand for temporary accommodation, except in real emergencies, has been almost eliminated by the preventive work undertaken by the area welfare officers. These officers have a close liaison with the housing authorities and, by undertaking regular visiting (sometimes including rent collection), have prevented eviction in many instances.

506. Liaison with housing authorities on these or similar lines was recommended by the Housing Management Sub-Committee of the Central Housing Advisory Committee in 1955. The Sub-Committee investigated, among other things, " the practice and experience of local authorities in dealing with unsatisfactory tenants and housing applicants, and with regard to evictions." Their Report, *Unsatisfactory Tenants*,[1] posed the question of what happens to evicted families, and concluded that they can seldom find another home for themselves.

> " The usual result, therefore, of an eviction is either that the family have to share accommodation with another family—which is likely to mean that both families are overcrowded—or that the family is broken up, the parents being parted and the children separated from one or other parent. In either case the effect on the family, and particularly on the children, is likely to be serious. Local authorities investigating applications for houses know the effect upon a family of shared accommodation. The arrangements seldom last long, and the family drifts through a series of ever worsening lodgings until they are again evicted or come once more to the notice of the local authority as the occupants of an unfit house.

[1] *Unsatisfactory Tenants*. Sixth Report of the Housing Management Sub-Committee of the Central Housing Advisory Committee, H.M.S.O. 1955.

> The result of a family obtaining temporary accommodation from the welfare authority may also be unfortunate. The normal responsibilities of parents for their children are weakened, and where these responsibilities are already taken lightly, the tie of the family may be broken for good. Residence in Part III accommodation may weaken a family's sense of obligation to help themselves and yet, if they find no other accommodation they may eventually be required to leave and the children may be placed in children's homes. . . .
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> If a family deteriorates to an extent that so endangers the security of family life as to lead eventually to homelessness, the problem presented is one not only in the immediate present but one which, if no solution is found, may repeat itself in the next generation. The unsatisfactory tenants of today may very well produce the unsatisfactory tenants of tomorrow ".[1]

507. We fully agree with this, and also with the Housing Management Sub-Committee's view that the first emphasis in seeking a solution to many of the problems of families in temporary accommodation should be on the degree of responsibility which housing authorities can, and should, accept before and after eviction. Not all evictions are from council houses however, and with some families eviction may be only the final manifestation of more fundamental difficulties which will not be solved simply by finding a new home. There is, too, the incomplete family already mentioned, which lacks the support of a father, and the family which has come to be known as a 'problem' family. All these may be admitted to temporary care and, as pointed out in *Unsatisfactory Tenants*, there is grave risk of an ultimate break-up if new homes cannot be found or the necessary help given in resettlement.

508. Homelessness, the prevention of eviction, and the consequent ill effects on family life, concern more than housing and welfare authorities alone. Health, education, children's and voluntary services are often equally involved. Before it ever falls to the welfare department to provide temporary shelter and care, opportunities for preventive work must have been missed. Whichever service plays the major role an immense amount of time, effort, skill and patience will usually be required if an unsatisfactory family is to be successfully re-established in a home of its own. We do not think (and the foregoing illustrations confirm our view), that work with families in temporary accommodation can be considered apart from work with other families generally in need of health and welfare services, because many of these present similar problems.

509. It appears to us that a proportion of families are admitted to temporary accommodation in circumstances which could have been prevented if a case-work service had been available earlier. This applies particularly to eviction for non-payment of rent and also to many unsatisfactory tenants, and 'problem' families. We agree with the Liverpool Personal Service Society that the crisis of losing the home can become a turning point for the better if the opportunity is taken to give the kind of help required. We also think that experience shows the importance of follow up when families who have spent a lengthy period in temporary care are eventually re-established in a home of their own. Unless appropriate help is given at this point there is often a risk of fresh deterioration. This implies close co-operation between trained field workers and residential staff as well as with other workers in related fields.

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[1] *Ibid*, paragraphs 8–10.

(a) The blind and partially sighted

510. The questionnaire returns showed that local authorities make considerable use of voluntary organisations in providing services for the blind. Seventy per cent of authorities in England and Wales have agency agreements for one or more types of service, and 17 per cent co-operate with a voluntary body without the formality of an agreement. In Scotland all but three authorities provide services through voluntary organisations. Since the war there has been a tendency for authorities in England and Wales to assume more direct responsibility for administration and for the appointment of home teachers of the blind. In some areas these officers may then be seconded to a voluntary organisation for the day-to-day work, but there are now only a few voluntary bodies which retain responsibility both for appointment and deployment of home teaching staff.

511. Some authorities providing a direct service administer it centrally and the workers are also centrally based, though covering either the whole area or a defined district. Sometimes these districts are the same as the areas for other health and welfare services and have the same offices. There is thus opportunity for liaison with other workers; elsewhere co-ordination at field level by this means may be lacking. This pattern is varied in some localities where day-to-day administration is undertaken and home teachers are based on local offices or work from their own homes. A third pattern is taking shape in one or two county areas where district welfare officers are encouraged to take the home teachers' examination and to combine general welfare duties with services for the blind. In a few other authorities, with the consent of the Minister of Health and on an experimental basis, home teachers provide services for the deaf or the general classes of handicapped persons. These developments are discussed further in paragraph 523.

512. Arrangements for regular discussion with a senior officer or colleagues in other services appear to be by no means general. One home teacher, stressing the need for closer collaboration with other workers within the authority, instanced the accidental discovery that three of the families containing a blind person in her case load were being visited concurrently by the mental deficiency worker. If there is an agency service the home teachers may work from the voluntary organisation's office or their homes. Liaison with field workers in other services may be less easy in these circumstances and will depend largely on the extent to which direct contacts are encouraged. In at least one area of which we had information the isolation of the home teachers from these other workers was very marked.

513. A characteristic of agency agreements in this service is that they may be made with more than one voluntary organisation, which in turn may also provide specific services for several other authorities. One large county, for example, has agency agreements with 20 or so voluntary societies for different aspects of the service: thus general welfare, home visiting, social activities, and handicraft centres are provided by one group of societies, and workshops or home workers schemes and placement in employment by another. Some of the latter group also provide these services for neighbouring authorities. In this area the home teachers of the blind are appointed by the local authority but seconded for duty to the various organisations with which there is an agreement. This is admittedly an extreme example of agency agreements,

but it indicates how fragmentation of the service may present a major obstacle to effective co-operation. It also illustrates the haphazard growth of work with the blind, the astonishing complexity which can result from it and the difficulties which face both local authority and voluntary organisation in meeting the needs of blind persons which seldom conform to geographical or administrative divisions of responsibility.

514. Information on staffing and conditions of work has already been given (paragraphs 336 to 338 and 389 to 391). Home teachers of the blind comprise the second largest group of workers covered by our inquiry and their numbers indicate the growth and development of the service. They show, too, that work with a specific type of handicap appeals to many people. Sometimes the occurrence of blindness in the family has first roused interest, or employment in some other sphere of social work has proved uncongenial ; for example, a home teacher who had previously worked with mental defectives stressed her preference for dealing with ' normal ' people. A small number of home teachers are themselves blind.

515. The information in paragraphs 336 to 338 relates to 601 home teachers of the blind, of whom 534 held the Certificate of the College of Teachers of the Blind, but we have no information as to the number who have completed a training course. The home teachers' representatives pointed out that there was no training when many of them entered the service. Even since it became available officers have been appointed untrained on the understanding that they sit for the examination within two years of appointment. Some have attended short training courses, others have taken the examination by a correspondence course and subsequently obtained appointment as a qualified home teacher without having had either training or practical experience.

The functions of home teachers of the blind

516. The functions of home teachers include the discovery of blind persons and the ascertainment of their needs. In assisting blind people to overcome the effects of their disability they help to ease shock, to create confidence, and to demonstrate ways in which normal activities can be continued to a greater or lesser extent. The family of a blind person is helped to adjust to the situation and to avoid the natural tendency to over-protect the newly blind member. The home teacher arranges for attendance at hospital if required, alleviates anxiety on practical matters such as mobility in the home and outside, and advises on the financial and other benefits available. She discusses the possibilities of social or industrial rehabilitation and may help, in co-operation with the disablement resettlement officer or placement officer, to set these arrangements in train. With pre-school children, or school children home on holiday, the home teacher of the blind does what she can to ensure that home conditions are satisfactory, and that the parents are encouraged to allow the child freedom and independence from an early age. The elderly gradually going blind now form a high proportion of new registrations. There are often difficult personal and social adjustments to be made while practical help may also be required.

517. We found a good deal of agreement about the proportion of older people in home teachers' case loads. This is consistent with the national statistics (quoted in paragraph 273), which show that over 60 per cent of blind

persons, and nearly 80 per cent of those newly registered in 1957 in England and Wales, were 65 years of age or over. In Scotland the equivalent figures were 58 per cent and 73 per cent. Twenty-two per cent of registered blind persons in England and Wales were also mentally or physically handicapped. These proportions are significant in terms of the services required, particularly since some social services for the elderly may be equally appropriate for the elderly blind.

518. The practical and psychological value to the blind of being able to read or write in embossed type and of simple creative work has long been recognised. The importance attached to this function in the training and examination of home teachers has perhaps encouraged the conception of a visiting teacher who also provides other services, rather than a home visitor or social worker who sometimes also undertakes the teaching of braille or moon and handicrafts. The evidence from the voluntary organisations for the blind pointed out that not all blind people wished to be taught these activities or indeed were capable of learning them. A figure of less than 10 per cent was frequently mentioned in this (and other evidence) as an approximate proportion of blind people learning braille or moon in any one teacher's case load. These witnesses emphasised, however, that age in itself was not necessarily a barrier to proficiency if an individual had sufficient desire to learn.

519. The teaching of crafts to the blind has long been regarded as part of the work of home teachers. It is included in the training syllabuses and examination, and qualified home teachers are expected to be proficient. It appears to us however that even among those learning to read embossed type there will be some, usually elderly people, who will be disinclined, or unable, also to undertake craft work. We consider this further (paragraphs 686 to 689) in discussing the evidence for a specialised service for the blind. Here we may say that we see no reason why craft teaching of the blind should be regarded as entirely separate from similar instruction of other handicapped persons. We recognise that skill is required to teach by touch rather than by visual methods ; nevertheless there are good reasons, for example in exploring new crafts and in marketing of goods, why craft teaching to the blind should benefit from the advice, experience or practical skill of an occupational therapist or skilled craft instructor, or from being part of a general occupational therapy or craft service for the health and welfare services as a whole.

520. The organisation of social clubs takes much of the home teacher's time. We have no doubt that such activities are important in preventing isolation, keeping blind people in the life of the community and providing opportunities for social contacts and recreation in a congenial setting. Many home teachers use voluntary workers to assist in this work. There is much to commend this practice, which gives the blind the opportunity of additional companionship and at the same time enables the qualified worker to spend more time with those who need most help.

521. Home teachers also undertake work with the deaf blind and others with more than one handicap, including loss of sight. They have similar responsibilities for the partially sighted, but the needs of this group are not at present adequately covered in the training syllabus and examination, while caseloads

were generally said to be too heavy to permit much attention being given to this side of the work. Some of our witnesses said they would like to see the partially sighted better cared for, and drew our attention to the fact that the registers for this group indicate only the number of those who applied for registration as a blind person but who had not sufficiently lost their sight to be so registered. They do not indicate the number of those with failing, or insufficient, sight who have not applied (or who do not wish to apply) for examination.

522. The needs of the partially sighted are not necessarily any less urgent than those of the blind, indeed there must be instances when they are clearly more urgent. Although the home teacher's experience in helping people to adjust to loss of vision is valuable in this connection, we think there will be occasions when she would not be acceptable to someone clinging to the hope of improvement or restoration of sight. In this situation a trained social worker who is not associated solely with blindness may be more effective simply for this reason.

Recent developments in the use of home teachers

523. Reference has been made (paragraph 511) to current experiments in the use of home teachers in England and Wales. When the National Assistance Act empowered local authorities to provide services for other groups of handicapped persons there was some natural anxiety about a possible dilution of the service to the blind if home teachers were asked to undertake other duties. This was recognised in the safeguards laid down by the Ministry of Health on the use of these workers in the new services, and so far only a few authorities have sought the Minister's consent to proposals of this kind. These experiments are interesting because they show a desire to make the training and experience of home teachers more widely available, and also demonstrate a move away from specialised services. The intention is to widen the home teacher's function so as to include work with other types of handicapped persons. So far as we are aware, there has been no accompanying recognition of the necessity for additional training before they undertake new work; nor does there appear to be any planned in-service training to enable them to do so with appropriate knowledge and skill.

524. In a few areas unqualified workers have been appointed to assist home teachers and to enable them to concentrate on their teaching functions. In one authority these workers undertake straightforward work and the home teachers concentrate on the newly blind, though retaining an overriding responsibility for all blind people. We were told that, although not originally in favour of the plan, the home teachers now regarded it as a way of doing more intensive work and were satisfied that they could take over again if necessary. The success of these arrangements would seem to depend on the unqualified workers being adequately supervised and also on their being sufficiently trained to recognise when a situation was deteriorating or a more skilled worker was required.

525. The other type of experiment mentioned has been made by a few authorities who have widened the functions of the welfare officers to include work with the blind among their general duties. In one county these officers are all either qualified as home teachers, or are preparing to take the examination. This authority holds the view that its officers are dealing

with people who happen to be blind, rather than 'the blind' and that many similar social needs arise from different handicaps. This point has been made to us in much of the evidence, and is discussed further in paragraphs 684 to 685.

526. It is clear from the evidence, and the trend in some areas towards directly administered services, that many authorities are questioning the general principle of providing a separate service for the blind. This is partly a result of the changing age structure of the registered blind. It is also influenced by the development of services for other handicapped persons, the desire to make fuller use of the training and experience of home teachers, and the recognition that the services for the blind are designed to meet certain fundamental needs which are common to all manner of severely handicapped people. These considerations have a direct bearing on the training required by workers with the blind, and also on whether the training and examination for the home teaching certificate gives a sufficient preparation for social work in view of the small proportion of blind people who wish to learn braille, moon or handicrafts. We consider this further in paragraphs 895 to 896.

(b) The deaf and hard-of-hearing

The deaf

527. The services for the deaf under the National Assistance Act are a pioneer effort. At present local authorities with approved schemes make considerable use of the experience of the voluntary societies and missions, usually through agency agreements. The general tendency for a statutory authority to seek the help of a voluntary organisation at the outset of a new service has been reinforced in this particular service by the fundamental difficulty of establishing communication and rapport. The majority of authorities have been glad therefore to rely on the staff of the voluntary organisations for the deaf.

528. The present picture shows that of 144 authorities with schemes, 92 per cent of the English and Welsh authorities and all the Scottish authorities, provide services in this way. Twenty-seven per cent of all authorities co-operate with one or more missions or deaf institutes without the formality of an agency agreement. Some which have not yet used their powers to provide a service nevertheless contribute to the work of voluntary societies, sometimes by use of premises and equipment, or by providing clerical help. The questionnaire returns showed that, like the blind societies, some missions or institutes are serving several authorities. The geographical areas covered are greater however, and in some instances as many as 8 or 9 authorities are being served. In such circumstances the staffing resources of the voluntary organisations may be insufficient to give the amount of individual attention which deaf people require.

529. During the last few years a few authorities have begun to provide some services directly while continuing to rely on the missions and institutes to meet social and religious needs. Usually the authority appoints a worker already able to communicate fluently, or an existing member of the staff is encouraged to study for the examination of the Deaf Welfare Examination Board under the guidance of an experienced missioner or deaf institute welfare officer. In these authorities the deaf welfare officer may work only with

the deaf or may combine such work with general duties. In one county the officer concerned with the deaf is assisted by the welfare officers, who have acquired reasonable fluency in communication under his tuition. This officer helps his colleagues with difficult cases or takes them over himself and this arrangement is regarded as an essential part of the service. The experience of the welfare officers in this area suggests that a degree of communication sufficient for day-to-day work with the deaf can be attained through instruction from a skilled colleague.

530. Opportunity for consultation and discussion with a more experienced officer and with other colleagues is particularly important in this service if deaf welfare officers are not, like their clients, to become isolated from other related services. This is especially desirable if there is an agency agreement and the authority relies in the main on the agency staff. Officers of the voluntary organisations have worked alone in this field for so long that it may not be apparent at first to either statutory or voluntary partner that each requires the help of the other if an improved service is to be given.

The functions of welfare officers to the deaf

531. At present local authority officers providing a direct service undertake home visiting, attend social centres, provide interpretation when required, and help to ease tension and the misunderstandings which frequently arise between the deaf and their relatives, friends and neighbours. The main attributes needed in this work are fluency in communication, understanding of the deaf and the psychology of deafness, and a social work background or training. Arranging for practical assistance as, for example, in obtaining a home help, can play an important part in integrating this new service with other health or welfare services.

532. The staffing of the directly administered services has been referred to in the previous chapter (paragraph 339). The officers in this service (other than district welfare officers) had all had relevant experience with a voluntary organisation before appointment to the local authority, and one or two were themselves handicapped by defective hearing. It is encouraging that these experienced workers should be attracted to the statutory service, and we hope that others will be similarly inclined if the opportunity is offered them. It is clear there is much pioneering to be done if local authorities are to provide an adequate service, especially in helping officers without relevant experience or training to learn to make contact with the deaf.

533. The voluntary organisations told us that their greatest need was for more staff to improve the service given and to reduce overwork. Pressure was said to be such that it is not always possible to carry out regular visiting of the deaf in mental or other hospitals or in residential care (especially in the former poor law institutions in isolated parts of the country). In some areas visiting in mental hospitals is a separate part of the work. We were told more women recruits are needed and it seems this work has attracted men more than women. It also attracts workers with a background of contact with a deaf person, frequently a close relative. There are now fewer ordained missioners than in the past, the majority being in the south of England where the work was pioneered by the churches. We understand that except for religious duties their work is similar to that of other staff, and distinct from the normal work of the churches. In common with other

voluntary organisations, some part of staff time is normally given to fund-raising, though grants from local authorities are said to have improved the financial position somewhat since 1948. Wherever we were able to meet officers of the voluntary organisations we were impressed by their devotion to this difficult work, and the value of their experience in this field. They have long been accustomed to the dual responsibility of interpreting their deaf clients to the community, and the world at large to the deaf: they now have a new responsibility of interpreting the needs of the deaf to the local authority, and of assisting in consolidating and expanding the service.

The hard-of-hearing

534. There has been little significant development in this field as yet. A number of authorities in England and Wales contribute to local centres for the hard-of-hearing, but less than a dozen have agency agreements. Some provide advice and free use of premises in addition to financial aid, others offer facilities in the authority's own social centre or club on a regular weekly or monthly basis. The evidence from the British Association of the Hard of Hearing emphasised the self-reliance of this group of handicapped persons, and their ability to deal with their own problems and difficulties. They were glad of help from the local authority service in obtaining social and recreational amenities but did not feel they normally required the assistance of a social worker.

Current developments

535. The difficulty of discovering the real needs of the deaf was mentioned by many witnesses, and it seems certain that these have yet to be fully explored. Even though current advances in ascertainment and treatment of defective hearing (referred to in paragraph 290) suggest a probable and greatly welcome decrease in the number of profoundly deaf children who do not learn to speak, there will always be some who do not respond to auditory training (especially among those with poor intelligence) and who will never have intelligible speech. This group may be smaller than at present but the isolation of individuals will often be correspondingly greater. It will therefore be essential, as at present, to promote and foster contacts between the deaf and other members of the community. There will always be in addition adults who lose their hearing in later years, or become deafened through accident or illness, and for whom services will be required.

536. On the evidence we have received, the health and welfare services clearly have a major challenge ahead as they try to meet the social needs of both the deafened and the profoundly deaf in a wide range of age groups. Experiment is needed to discover ways of meeting the individual and social problems of the young and adolescent, as well as of adults and the old, and further research to throw light on the effect of total deafness on personality development. When we reflect that language, the ability to communicate with others, and to think in abstract terms is the basis of civilisation we can only infer that deafness may affect personality more profoundly than any other physical handicap. The general public must also be helped to understand and live with people handicapped by deafness in the same way as they accept the handicap of the blind.

(c) **The general classes of handicapped persons**

537. We referred (paragraph 298) to the uneven development of these new services throughout the country and to the experience already gained which

shows them to be meeting a hitherto unrevealed need. At the outset it was expected that the services required would be broadly comparable to those for the blind and deaf. There has been, in fact, a greater emphasis on occupational activities, on social and craft centres of all kinds, and on the supply of gadgets, aids to living, and structural adaptations in the home. This practical assistance supplies a handicapped person with occupation, interest and, in some cases, mobility and a wider range of social activities and, in addition, makes it easier for the family to care for the disabled member. The meeting of less tangible needs such as may be necessary in easing family tension or strain calls for staff who are able to recognise when such help is needed, and are qualified either to give it themselves, or to know when to refer to a more experienced or highly skilled colleague. In those authorities where the emphasis is on home visiting welfare officers have sometimes commented that this often discloses, not only the need for gadgets or other practical assistance, but also family attitudes to the handicapped person and his disability, and that it is here that help is often most urgently required.

538. The pattern of co-operation between statutory and voluntary organisations varies in this service, as in others. The general tendency to provide a direct service gradually has held good, though a few authorities were quick to grasp the opportunity of pioneering a new service. The majority of English, Welsh and Scottish authorities with approved schemes have agency agreements with voluntary organisations for one or more types of service, but 28 per cent in England and Wales provide a direct service without apparently making use of voluntary agencies.

539. Some authorities have given first priority to structural adaptations, facilities for handicrafts or occupational therapy. Elsewhere social centres or clubs, with accompanying arrangements for transport, have been provided first. Yet other authorities have established holiday schemes, especially for the severely disabled, some of which require a considerable amount of planning. A few examples will illustrate these varying arrangements. In Birmingham a combined statutory and voluntary service has been built up, based on the welfare department's area offices. The voluntary organisation is responsible for stimulating and co-ordinating voluntary effort, and for providing a friendly visiting service, while the local authority provides occupational therapy and craft instruction and undertakes social work with individual or family problems. In Middlesex the authority has built up its own visiting staff, recruiting social science qualified workers where possible, and has appointed staff to organise out-work for factories at special centres or in the homes of handicapped persons. This authority also assists a number of voluntary organisations in running handicrafts and social clubs, and co-operates in providing holidays for handicapped persons. There has been a comparable development in Bristol. In Buckinghamshire almoners in the after-care service under the National Health Service Act also undertake casework with the handicapped, and the occupational therapy service for the tuberculous has been extended to the homebound disabled. In an industrial county borough, on the other hand, the emphasis is on rehabilitation and employment. A close link with the Ministry of Labour and National Service has enabled a number of handicapped persons to pass on to an industrial rehabilitation unit and thence to open employment. Experience

suggests that this type of development is mainly successful with men, but that disabled women tend to be more interested in social activities, and in aids to living in the home. In a few areas some non-infective tuberculous or mentally disordered persons also attend social or craft centres.

540. Most of the authorities included in our inquiries provided a direct service and also co-operated with appropriate voluntary organisations; two had not yet used their powers to draw up a scheme. For the most part the services which were directly administered were decentralised and the work was undertaken by welfare officers, either alone or in co-operation with visitors for the handicapped, occupational therapists, or the workers of the voluntary association for the handicapped.

541. The importance of good publicity for a new service was illustrated in one authority by the way in which the names of handicapped persons reached the register. The sources of referral most frequently mentioned were hospital almoners, Ministry of Labour and National Service and National Assistance Board officers, workers from other local authority departments especially the health department, various voluntary organisations, general practitioners, the clergy, relatives and others. The case load of one officer showed that out of 54 recent registrations 10 had been referred by hospital or local authority almoners, 8 through the welfare department's own publicity leaflet, 6 by social work organisations, 5 from general practitioners, 9 from relatives or the handicapped person himself, 3 from the disablement resettlement officer, 2 from the National Assistance Board, 4 from the education department and the home nurse, and the remaining 7 from miscellaneous sources, including a pension society and a solicitor.

542. We were glad to find that the need for discussion and consultation between workers is usually recognised in this service. The setting-up of joint associations for the handicapped by local authority and voluntary organisations has been an interesting development in some parts of the country. A few cover more than one local authority area. These bodies serve a valuable purpose, not only in demonstrating that the need for co-operation is recognised by those attending the meetings, but also in making known to each other, and in bringing together in common purpose, officers of voluntary and statutory organisations. Some of these associations were promoted by combined voluntary effort, often with one organisation providing the stimulus and the secretariat. In others, the local authority has been the moving spirit, and officers play a leading part or provide administrative or secretarial help. We refer to this type of co-ordination and co-operation again (paragraph 1081).

543. Details of staffing have been given (paragraph 340). Like the home teachers of the blind (a few of whom are now engaged whole- or part-time in this service) these officers have a variety of background, training and experience. A very few are almoners, the majority are welfare officers (some with Poor Law experience) who also have other duties. Many of the visitors to the handicapped have a social science qualification or experience in social work. The ratio of social science qualified workers is higher in this service than in the others with which we are concerned, which indicates that efforts have been made to recruit staff so qualified, and also that it is attractive to people embarking on a social work career.

The functions of visitors to the handicapped

544. Welfare officers and visitors to the handicapped undertake preliminary visiting and inquiries in connection with registration, the assessment of need and the type of service required. This may involve reference to general practitioner or hospital for medical guidance or advice, the provision through the hospital of a wheel chair or other appliances, arrangements including transport for attendance at social or craft centre, or application for ramps or structural alterations. In appropriate cases they refer to a trained case-worker, an occupational therapist or craft instructor and seek the help of disablement resettlement officers or the housing authority. They get in touch with appropriate voluntary organisations including old people's welfare committees, but there has been as yet little link up between these facilities and those for older handicapped people. They endeavour to help the handicapped to live as full and independent a life as their disabilities permit, and try to ensure that the environment is as favourable as possible. They co-operate with medical, health, education, vocational training and employment, or voluntary services as required.

545. The importance of occupation and social activities in helping homebound or severely disabled people to feel part of the community has been mentioned above. Many field workers in this service, like home teachers of the blind, are attached to social or craft centres or to clubs. In this way they see some of their clients regularly in a community setting as well as in the home.

Occupational therapy and craft teaching

546. There has been a considerable development of occupational therapy and craft teaching. The questionnaire returns showed that about 100 occupational therapists and craft instructors were employed mainly or solely in this service, concentrated geographically in the industrial north and midlands, London and the home counties and in industrial Wales. The majority of occupational therapists mentioned in the questionnaire returns were thought to have a social work function subsidiary to their main employment but a few authorities regarded them primarily as social workers. This has sometimes led to confusion of function between occupational therapists and social workers. In the course of contact with an individual or family, occupational therapists inevitably become aware of social problems or needs. If a trained social worker is employed it is the practice for them to work together in difficult cases, but if there is no appropriate worker to whom a social problem can be referred the occupational therapist may try to deal with it herself, especially if it has a bearing on her own work.

547. We see the rôle of occupational therapists as separate from, but complementary to, that of social workers, a view shared by the Association of Occupational Therapists. Occupational therapy requires a different professional knowledge and skill from social work, and has a different function in relation to clients and to general practitioners or other doctors. The contacts of occupational therapists with the National Assistance Board are about earnings and allowances, and with commercial and industrial firms about materials, out-work, and disposal of goods. Clearly there should be close co-operation between occupational therapists and social workers, and

it may sometimes be convenient for one to visit on the other's behalf, especially in rural areas. If occupational therapists are visiting regularly they can be of great assistance to social workers as a means of keeping in touch.

548. It has been suggested that the teaching of crafts, as distinct from occupational therapy, might be part of the functions of welfare officers. Where these officers have the necessary training and aptitude they could doubtless undertake this work if their case load allows, but many social workers have no aptitude for craft work and it would be uneconomical in our view to try to effect any general combination of functions.

Current developments

549. These new services are developing in varied ways with varying emphasis, depending largely on the staffing resources of individual authorities and the differing views about priorities. In rural areas, and especially in sparsely populated parts of the country, the difficulties of bringing services to the homebound, and of providing transport for more seriously handicapped people to attend social or other activities have still to be overcome. It is clear from the variety of provision already made, and the response to it, how great a need is being met. Sometimes this response, coupled with the enthusiasm and interest of the workers has tended to create a new specialisation. This was commented on in one field study.

> "The development of this comparatively new service provides an object lesson in the genesis of fierce loyalties to a new speciality. Already the workers insist that this service is quite different from that provided for the blind on the one hand and the mentally handicapped on the other. There is no doubt that these workers are learning a great deal about the nature of severe physical handicaps, are developing new skills and accumulating useful specialist knowledge regarding practical aids, and the management of handicapped people. They also provide a very useful link with the many voluntary societies . . . whose efforts need channelling. Although one could observe this genuine enthusiasm in gathering new knowledge and developing a new service, there was the danger of failing to see the handicapped person and his family and of concentrating instead on the handicap itself."

CONCLUSIONS

550. In this chapter we have attempted to summarise the present position in those health and welfare services which have a significant social work element. Many services have come under review and a number of perplexing problems have been indicated. The services themselves are at very different stages of development. In practice, if not in their present legal form, some of them stretch back for centuries; others involve work which is still new for statutory authorities. The importance and complexity of the services are not necessarily indicated by the numbers involved as shown, for example, by the problems of temporary accommodation. The social work element in some services has altered in recent years owing to changes in medical treatment, better facilities for rehabilitation and, consequently, shorter periods of incapacity due to illness or disease. This is seen in the tuberculosis service and in the social work required in venereal disease clinics. Other services, such as those for the elderly and the mentally disordered, are challenged by a great expansion in the numbers they must serve, and by new developments in the kinds of assistance which they will need to provide. Local authorities naturally differ in their interests and resources, and in the

urgency of the problems which compel their attention. This has led to an interesting variety of experiment to which we have been glad to draw attention ; as for instance in the use of trained social workers to assist general practitioners with medical social problems in health centres or group practices, and of family caseworkers and welfare officers in preventive work with families in danger of breaking up or threatened with eviction. Certain relatively new services have developed in strikingly different ways in different authorities ; the home help service, for example, has at its best shown a flexibility and imagination which has made it a valuable adjunct to a wide range of other services.

551. This review has brought out certain significant trends, perhaps the most important being increasing clarity about the purpose of the services. At first, attention was concentrated on the relief of human suffering and on ensuring tolerable living standards in so far as these came within the ambit of the services. Today these aims are affirmed afresh, but it is now better appreciated that public social services must actively promote healthy and independent living, for instance through the rehabilitation of the handicapped and of the so-called 'problem' families. There is a new emphasis on the contribution that social workers can make to the prevention as well as the alleviation of the social problems of individuals and families. There is also clearer understanding of the importance of maintaining the elderly and the mentally and physically handicapped in the community whenever practicable, and of keeping them, so far as possible, in touch with community life if they have to enter hospital or residential accommodation. The services are now more consciously planned and administered so as to help the family to care for its own handicapped member (as the family nearly always wishes to do). It has been put to us that the new emphasis on prevention and on domiciliary care is sound economy as well as sound social policy, and that it is certain to prove less costly than the alternatives of admission to residential care or temporary accommodation, or of receiving children into care. No reliable evidence is at present available to enable us to judge, though we think this likely to be true. We have no doubt, however, that if the criterion is the welfare of the individual and family, then the new approach is, generally speaking, the right one.

552. In the main, the services have grown separately to meet the needs of particular groups as these were seen to be important. To some extent this is still happening as the services for the general classes of handicapped persons become established. As we see it, the heart of the problem we are called upon to consider is how far do these distinct services correspond to separate human needs, and how far do they represent administrative attempts to cope with different aspects of the complexity of human problems. To what extent, for instance, do the physically and mentally handicapped, the socially inadequate or incomplete families share common social needs, and how far are their needs fundamentally different? Some differences are evident and important: some mentally sub-normal people need special understanding and care ; deaf people need help in communication ; some of the blind need help in learning to read and in occupying themselves. But today most of the newly blind are elderly: 'Old age never comes alone' and blindness is rarely their only handicap. Whatever the handicap the individual has to learn how to accept it and, in so far as it cannot be overcome, how to

live with it. The family also has to understand what the handicap means and perhaps to accept help in the stresses and tensions which it causes. There is need for effective use of all relevant social services—these needs are fundamental.

553. The existing sectionalisation of these services no longer makes sense administratively, in economy, or from the point of view of social work. With the kind of pragmatism that marks the development of our social administration, a few local authorities have sensed this problem and are experimenting with ways of meeting it. We have mentioned that some have been examining afresh the principle of providing a separate service for the blind, and others have decided from the start that the services for the deaf should not be separate. The experience of these authorities, though limited, confirms the view that a more general approach may provide the better and the more economical service. At the same time, we have noted a tendency in some areas for new specialisms to emerge with their own intense loyalties, for instance in the care of the general classes of handicapped persons.

554. The key to this central problem seems to us to lie in the staffing of the services and in the training of the staff. It is little help if functions are grouped but the staff are given no training to carry out extended duties. Since 1948 there has been no relevant training or qualification open to the majority of the officers in the services with which we are concerned. Such training as was available, for example for home teachers of the blind or deaf missioners, has been specialised in the sense that it is sectional, concentrating on one handicap. We must consider what training would enable the social workers within our terms of reference to meet a related group of needs more adequately than now, to appreciate what is common in a variety of human situations, and to recognise when other workers may be more appropriate. These themes of needs, staffing and training are taken up in succeeding chapters.

PART II

Chapter 4

THE NEEDS OF THOSE USING THE SERVICES

555. In the preceding chapters we have traced the history of the health and welfare services within our terms of reference noting the present legislative framework, the stage of development reached, the staffing picture and the work of officers currently employed. We have noted also the diversity of pattern in administrative structure and local organisation, and the variations in functions and responsibilities of individual officers according to local circumstance. We come now to consider the needs of those for whom the services are provided and the ways in which these may be most effectively met. We propose in this chapter to consider broadly the functions of a variety of officers who assist individuals or families with a specific need, a disability or a misfortune.

556. It is sometimes said in relation to the care of children and the prevention of break-up of families that local authorities cannot adequately meet the needs of families at present, and that a new service depending upon further statutory powers is required. Such comments are a further indication of the changed demand made on local government in this respect. Much more is expected of the statutory services today than twenty years ago now that the possibilities of family casework are more widely appreciated. Some authorities, as we have seen, are anxious to pioneer these new services. The real difficulty in our view is not lack of powers so far as the health and welfare services are concerned, but of a sufficient number of appropriately trained staff, and of effective co-operation between these and related services.

557. We have said (paragraph 10) that it was not possible to undertake inquiries into 'consumer reactions' complementary to the field studies. We therefore paid particular attention to this aspect on our own field visits, and asked our field investigators to do the same. These observations, and the case illustrations, provided us with some of the most valuable evidence we received on the working of the services, the needs of those whom they exist to serve, the contribution of different types of worker and the degree of skill required. Although the field studies were carried out in very different parts of the country, from the most urban to the most rural, and from north to south, and the investigators were not in touch with each other, their findings yet showed a remarkable degree of similarity, and corresponded with our own observations in certain respects. We and they were conscious of the general desire on the part of individual authorities and their staff to meet personal and family needs, and of the wide range and variety of the services, and the many problems from the simplest to the most complex with which the workers were concerned. The field investigators were as impressed as we were by the good work being done at a level within the competence of the worker, though we all saw a proportion of cases where more skilled help was required but was not being provided, either owing to pressure of

work or because of lack of sufficiently well qualified staff. The desire for training expressed by many of the officers concerned, to enable them to handle more effectively the very difficult problems with which they were often faced, also impressed us all. In their reports the field investigators continually referred to their contacts with the persons for whose benefit the services were designed, the problems they presented and the different degrees of skill which the workers would require.

Degree of skill required

558. This question of degree of skill is fundamental in determining functions. We do not take the view that everyone who is mentally or physically ill or handicapped, aged, socially inadequate, in danger of eviction, homeless or an unmarried or unsupported mother requires a highly trained and experienced social worker. On the contrary, we know that many people will deal with a crisis themselves, or with the help of family or friends, and never come to the notice of the local authority. Some, with appropriate help from the statutory services, are able to achieve and maintain an adjustment to circumstance, illness, or handicap which enables them and their families to live with a sufficient margin of content and security. Others may need skilled help at times of extreme stress, for instance at the sudden onset of blindness, but not once a successful adjustment has been made. Again, some individuals or families can carry what is often a very heavy burden of mental or physical sickness or disability in the home over a long period, if they can share some of the stress and strain with someone outside the situation. One of our witnesses in the mental health service, referring to the problems of mental illness and deficiency, suggested that many families can 'contain' a difficult situation, provided they have the support and help of a knowledgeable and skilled worker. This comment appears to us equally applicable to some other family problems. In such circumstances the social worker may be required to prevent a general breakdown of family care by giving support and understanding to one or more members, rather than by providing any more concrete form of help.

559. Some people are fundamentally unable to fend for themselves under modern conditions and will always make demands on the social services. They constitute a constant factor in the case loads of many different types of worker: among them are some unmarried mothers and certain families with consistently low standards of living and child care, sometimes amounting to neglect or ill treatment—the general pattern of social inadequacy familiar to all local authorities.

560. It is difficult to generalise about the diversity of handicapped or troubled people who come the way of the health and welfare services, since as much depends on the personality and strength of the person or family concerned as on the nature of the crisis, or disability, which afflicts them. Of four people with roughly comparable injuries admitted to hospital after a railway accident, one may need simply some information about the resources available to him in the way of compensation, insurances, etc.; another a straightforward service, such as arrangements for convalescence, or the provision of domestic help at home until recovery is complete. The third may require support through the crisis of illness, adjustment to permanent disability, rehabilitation, and resettlement; and the fourth intensive and long-term help

with personal or family problems which accident and incapacity may have brought to a head. In other words, social work would not be related solely to the medical diagnosis and prognosis, but rather to the personal and social reactions, implications, and consequences of the accident to the person concerned and his family.

561. It is, therefore, not only necessary to assess a situation correctly, but also to identify the greater or lesser degree of skill required of the social worker if the individual or family is to receive the help needed (which is not always the same as the help applied for). We have no doubt that the variety and degree of the problems met with in these services is such that more than one type of social worker is required. In addition to assessing the situation correctly and selecting the worker or workers (for more than one may sometimes be required), there must be appreciation of the point at which the skill or contribution of each should be introduced, and when the resources of other services (including the voluntary services) are needed. Sometimes there is no choice, especially in rural areas, and there is no other worker to whom to turn. One of the complexities in this whole inquiry has been the varying resources in terms of staff of large and small authorities, and of scattered and concentrated areas of population, a difficulty accentuated by the lack of training for social workers and the small number of trained workers available.

562. The contribution of workers in related fields is discussed in paragraphs 603 to 605 and in Chapter 10. Here our task is to identify the broad categories of human need met by the services, and to relate these to the functions of social workers. We have been much helped in this by discussion with witnesses representing the whole range of services ; with members and officers during our visits to local authorities ; and by the reports of the field investigators. We have reached the conclusion that the content of the case loads of social workers throughout the health and welfare services can broadly be divided into the following categories :

(*a*) People with straightforward or obvious needs, who require material help of various kinds, some simple service, or a periodic visit to see whether any change has taken place or to provide evidence of the continuing support and interest of the authority.

(*b*) People with more complex problems, who require systematic help from a trained social worker.

(*c*) People with problems of special difficulty requiring skilled help by professionally trained and experienced social workers.

These gradations are clearly social not medical assessments. We think they apply to every group, the mentally disordered, the blind, the deaf, the physically handicapped, the elderly, unmarried mothers, families in difficulties of various kinds, and to the social aspects of care and after-care under the National Health Service Acts.

563. We have not felt able to estimate the percentage in each category in any given service nor to make an overall estimate. No information exists on which such estimates could be based, but they are essential to sound decisions about appropriate staffing and deployment of staff. We **recommend** a variety of studies to determine types of need and appropriate ways of meeting them. We ourselves would expect the proportion requiring skilled

casework to be substantially higher among persons discharged from mental hospitals and their families, than, for example, amongst the elderly. Similarly, we think it probable that a variety of difficult family problems (especially amongst those without homes of their own) and a high proportion of 'problem' families would also come within this category, but that many of the blind or physically handicapped would normally come into one of the other two categories.

564. We must make it clear, however, that we are not thinking in terms of a particular situation or handicap, but of a total family situation and the presence (or comparative absence) of family, personal or social crisis and of stress or emotional disturbance needing the help of a social worker to restore and maintain social and personal balance, or ability to cope with the situation. This means that any given person or family might, at different times, be in any one of the three categories we have suggested. The elderly, for example, may often be in the first category for several years. If there is no family, or its members are not in touch, a visitor from a voluntary organisation may help to provide outside interest or activity and at the same time watch for any sign of deterioration. As the ability to manage alone decreases, more help will be required, often with personal worries, or in regard to health, domestic duties or meals. There may be discussion of the possibility of residential care at this point and the domiciliary services may or may not be sufficient to postpone this necessity for a time. Later, illness or accident may precipitate a crisis, or it may gradually become impossible for the elderly person to remain independent, and admission to a home must be arranged, with all the uprooting this implies.

565. Likewise the chronic sick and the physically and mentally handicapped may sustain life in the community for many years in spite of incurable ills. They are often more at risk than the rest of the population, so far as stress, frustration, crises and failure are concerned, and the situation is always liable to break down if social isolation increases, or if circumstances change. The family with many young children may prove an almost intolerable burden for a worn out or inadequate mother, but the basic strength of family affection may make it socially as well as economically desirable to provide periodic or continuous help through a skilled worker while the children are young and thus to keep the family together. The situation will often improve as the children grow up, and if so a less skilled worker can maintain a limited contact if need be. The right kind of intervention at the right time reduces the risk of breakdown, and the individual or family concerned may suffer far less stress and strain than if such help had not been available.

566. We are not suggesting by this that people who use the services should be passed like parcels or commodities on a conveyor belt from one type of worker to another. In each department, there should be specific arrangements to ensure that the needs of each new case are fully assessed, that it is allocated to an appropriately qualified worker and that progress is periodically reviewed. We think that a less skilled worker will often be able to carry a case with which he is familiar over a difficult patch if he has the opportunity for detailed discussion with, and guidance from, a more experienced or skilled colleague. We cannot generalise as to the point at which the worker with greater skill will be required, but the facts of the situation, and the staff available in the particular department, will usually indicate when a more

experienced officer must be brought in. In the same way a skilled worker will recognise the point at which a less skilled colleague can take over. This would mean, for example, that a newly blind person or one losing his sight would be under the care of a qualified and experienced worker during the period when he was adjusting to the problems of blindness, but that when this had been achieved another worker could take over responsibility. These decisions, which affect the relationship between worker and client, should as a rule be taken on social rather than on administrative grounds. The family or individual should always be prepared some time beforehand for the impending change, and the new worker should be personally introduced.

(a) *Straightforward or obvious needs*

567. Perhaps the simplest service which all local authority staff (not only those within our terms of reference) are called upon to give is straightforward information and advice—advising the citizen as, for example, in a local authority information service or citizens' advice bureau. To give such advice acceptably requires good public and personal relations, as well as sensitivity to the reactions of a wide variety of people, particularly as an initial enquiry may often prove to be less simple than originally appeared. Closely related to the giving of information and advice in this sense is the difficulty which many people have in filling up official forms or understanding official letters. We were much interested to find that in at least one area the mental welfare officer, instead of posting official letters to parents or guardians of mental defectives, sometimes conveyed them himself in order to give a verbal explanation. This may seem a simple matter, but the whole relationship between an individual and an authority may be vitiated if written communications from the latter are in incomprehensible official language, or cannot be easily understood. We regard it as of first importance in building up a good relationship between local authority staff and the general public, that straightforward information and advice should be given acceptably as well as accurately, that letters should be written in simple terms, or an immediate verbal explanation should be provided if this is not possible or if the contents are likely to be distressing.

568. Regular visiting, especially of certain elderly or handicapped people, may be undertaken by a voluntary organisation or voluntary workers, or by local authority officers. The contribution of voluntary effort is discussed in Chapter 11. The purpose of regular visiting by local authority officers is to ensure that the care of the person concerned is satisfactory, to give practical assistance or help, or to arrange social or occupational interests and activities. The visiting officer need not, and usually does not, require a full social work training for this purpose, but he must have sufficient training, in addition to the right personality, to enable him to recognise when more skilled help is required, or a different type of service should be called in. He should always work under the supervision of a more skilled officer.

569. This type of worker was described by some witnesses as a social aide and by others as a welfare assistant. Though it is perhaps not entirely satisfactory we prefer the latter term. The welfare assistant can help with practical problems such as sorting out difficulties in connection with pensions or allowances, or registrations for housing. He can make arrangements for holidays or a meals service, encourage attendance at club or other social

activities, refer to the appropriate service for training, employment or other need, and keep in touch with those awaiting admission to residential care. The field studies all gave instances of this type of visit. The following example shows how practical help made it possible for a family to carry on independently.

(1) A young married woman with children, partially paralysed and confined to a wheel chair. The family situation was stable and her lack of mobility the only problem. Considerable structural alterations were carried out in the home to enable her to work in the kitchen, bath her children and put them to bed, and to move about freely in her wheel-chair. Many obstacles had to be overcome in order to complete the alterations, but eventually she was once more able to carry out her functions as housewife and mother.

570. The following records of visits illustrate situations where there were no immediate problems.

(2) A mental defective in regular work, known to the mental health service for many years. Her family was united and looked after her well and she had never given cause for concern. The mental welfare officer represented someone interested in her progess, and visited about once a year to keep alive the idea that the family need not hesitate to ask for help if in difficulties.

(3) A blind middle-aged single woman, who had no wish to learn braille or handcrafts, living with a friend who went out to work. Material conditions were adequate, the relationship between them amiable and there were no outstanding problems. The blind woman did a great deal of the housework and the running of the home, and the friend took responsibility for shopping and for arranging outside activities, and the blind woman's holidays.

571. Many handicapped people make a good adjustment to their disability and can go about their affairs independently, or are well cared for by their families. If they are blind, the teaching of braille, moon or handicrafts may not be required (as in the illustration above) or further tuition may be unnecessary. Each of the field investigators noted that a major part of the time of home teachers of the blind was spent on visits of this general nature.

572. It is sometimes questioned whether regular visiting by local authority officers is justified if there are no apparent difficulties, and the family situation is stable. The question arises particularly in regard to mental defectives under guardianship or statutory supervision in England and Wales. At present there is a statutory obligation that such defectives should be visited periodically as may be considered necessary. Some mental deficiency visitors told us that in their experience it could rarely be said that help would never be required. Others thought that some families might hesitate to call on them in a difficulty if they were not in regular touch ; in their view even a yearly contact was valuable for this reason.

573. There are similar considerations in the long-term care of the severely handicapped. It is sometimes said that social workers are only called in in time of crisis, and in some circumstances this is true. It should not be so if visiting is planned selectively, and if potential difficulties are foreseen, so

far as possible. An example which came to our notice was an elderly paraplegic craftsman living in comfortable surroundings and fully employed : his wife, who was older, cared for him devotedly and no specific services were required. He was clearly entirely dependent on her and would be utterly at a loss if she were to die, or otherwise become unable to look after him. There would be considerable practical difficulties in either event, but the main necessity might well be to help the husband to adjust to a new and frightening situation at a time of great personal sorrow. If a regular visitor was in touch the husband would have someone to whom to turn immediately, even if a more skilled worker was subsequently required to help over the crisis.

574. In our view, and apart from statutory obligations, the necessity for regular visiting should never be taken for granted ; there should always be periodic review of situations which are apparently stable. At the same time we are satisfied that there will be many instances when there are sound arguments in favour of regular, even if fairly infrequent, visits. Often an occasional visit may be all that is required, provided that those concerned know how to reach the visitor if the need should arise, or that arrangements are made with a member of the family, the general practitioner, or other reliable person to notify the department concerned if the situation deteriorates.

(b) *More complex problems requiring systematic help from a trained social worker*

575. A request for a straightforward service or material help may sometimes reveal a situation which is far from simple, and may, like an iceberg, be only the emergent tenth of a total problem. An application for a wheel chair may reveal a complicated family situation of over-protectiveness or dependency similar to that described in paragraph 583. An elderly person recommended for a meals service may, in fact, require a range of domiciliary services to avoid the necessity for residential care. When admission to a residential home is desirable several visits, and much time, will often be needed to ensure that the old person really wants to go into a home, and understands what this will involve. One visit recorded the following situation.

> (4) An old lady of over 80 living alone in a spotless and well furnished flat recommended for admission to a home by her doctor. She was confused, forgetful, and not able to tell a coherent story. It was doubtful if she was drawing her pension regularly, or could manage her financial affairs. She cooked very little, and it seemed possible that her mental confusion might be partly due to lack of food, and that her difficulties could be lessened by a home help, a meals service and regular friendly visiting. The welfare officer proposed to arrange these services, to keep an eye on the financial situation, and to consult further with the doctor before deciding whether to try to persuade the old lady to give up her home.

576. Similar illustrations are found in the home help service. One organiser observed to the field investigator that the actual provision of a home help was a comparatively simple administrative matter, but it might alleviate only one element in what was often a very complicated situation.

577. It sometimes happens that people are unwilling to admit that they must look to strangers for help, or to receive it from them. The social worker must understand these feelings and use his skill in reducing them to a point at which the offer of service will be accepted. Examples are found among the mentally ill who cannot bring themselves to recognise their need for medical treatment or to accept it, and with elderly or aged persons on the verge of requiring compulsory removal to hospital or elsewhere under Section 47 of the National Assistance Act. The latter are often only discovered at a late stage if there has not been close co-operation between statutory and voluntary services, so that help is given in time.

578. There are other less extreme situations where timely help could prevent breakdown as, for example, the wife wearing herself out looking after her family and a bed-ridden husband, who will not agree to seek help in the house; the tuberculous patient who refuses to persevere with treatment; the severely handicapped person fearing to venture out to a club or social centre for the first time. The social worker must understand the reason for the reluctance to accept help, and must know how to offer it so that both the underlying and the obvious need is met.

579. Support as well as practical help is often required by those without family or friends to whom they can turn—a group in which unmarried or unsupported mothers are often prominent. One of the field studies described the help given by the matron of a mother and baby home to an unmarried mother deserted by the father of her child. Practical arrangements were in train for the girl's future but she responded best to the matron's support, saying: " She is the only one I have who will fight for me ". This comment underlines the important part which residential staff can play in support, rehabilitation and preparation for a return to the community.

580. In some of our visits it was clear that the visiting officer provided both support and practical help. This was especially evident with families caring for mental defectives.

> (5) A family where there were three adult defectives, two of whom had children attending schools for educationally sub-normal children. The trained social worker had seen this family through many vicissitudes. He kept in close touch over many years, patiently sorting out their many problems, encouraging them to keep on trying, and never letting them feel they were a ' hopeless lot '.

581. Caring for a mentally defective child may often place a heavy emotional and physical strain on the family. The social worker must be able to give steady and continuous support, eventually perhaps helping the parents to evaluate the respective claims of their normal children and the defective child. In one instance the mother of a seriously defective child saw the problem only as one of obtaining help to enable her to carry on somehow. But the observer could see other problems.

> (6) The mother was over-protective towards the child, and may have felt responsible for his defect. She found it hard to accept that he would never improve. The worker could arrange for a home help, or perhaps in time offer a vacancy in hospital, but a further service could be offered, that of helping the mother to talk about her feelings about having borne a defective child. This would need much more understanding and skill

than simply arranging a service. The worker must know whether such help would be appropriate in this case, and obviously mere reassurance would be useless. Time, good understanding of the mother's feelings, consultation with the medical advisers, and real skill in giving the right kind of support would all be needed. This kind of service is well worth giving, because the happiness of the whole family may be involved.

582. A child with a congenital physical handicap or with more than one defect can impose comparable strain—the severe spastic or epileptic, the child who is born blind or deaf, or both, and children with progressive or chronic disease. The parents may find it hard to admit that something is wrong, or they may be unable to obtain a definite diagnosis. The primary consideration must always be for ascertainment, medical diagnosis and medical or educational treatment. At the same time the parents will often need as much help as the mother of the mentally defective child in the preceding illustration, particularly if important decisions which affect the child's future, for example about residential schooling, have to be made at an early age.

583. A handicap acquired in childhood or later life may also result in over-protection. In one field study a trained social worker had been concerned in a long standing situation of this kind.

(7) A single man, living with his family, who had had rheumatic fever as a child and whose mother, imagining he had a weak heart, kept him in bed so that he did not return to school. In consequence he had become wasted, his legs were flexed and he was unable to walk. When the welfare officer began visiting he was told by the doctor that further medical treatment had been refused and that probably little could be done at this late stage. The welfare officer visited regularly and provided various appliances suggested by the doctor to encourage exercise. arrangements were also made to take the young man on outings. The mother remained resistant to all attempts to get him back to hospital, but eventually, after much perseverance, an invalid tricycle was supplied through the hospital to encourage a fuller life within the limits of the disability. The young man now goes out daily and has joined the club for the disabled where he meets people more severely handicapped than himself but living far more independently. In time the welfare officer hopes to find him work within his capacity, or to get him sufficiently mobile to be considered for admission to an Industrial Rehabilitation Unit.

584. There is sometimes a tendency to ignore fathers, or to fail to help them to fulfil their family obligations. One instance of this was described in a field study.

(8) A large family where all the children wet the bed and the home was very dilapidated ; the father appeared to be an immature person who did not keep his jobs or get up in the morning. A home help gave the mother practical assistance in keeping the home clean but the other problems were not being tackled. Some time later the investigator enquired about the family, and learned that one organisation had offered to 'deal with the father'. Thereupon he disappeared, the mother felt

obliged to go out to work, and the home help was stopped. Later a court action was brought against the mother for neglect and the children were scattered into nurseries or received into care.

This is an almost classic example of a final outcome which all concerned would have wished to avoid. It also shows how greater local authority expenditure may ultimately be caused by lack of co-ordination of effort, in addition to lack of social assessment and casework.

585. Fathers are also frequently left out of temporary accommodation. There may sometimes be practical reasons for this, as for example, where the accommodation in former public assistance institutions is unsuitable. But where there are no considerations of this kind we hope the exclusion of fathers is not an invariable rule. A proportion of the homeless families which come into temporary care are only just holding together as a unit, and there is often instability or mental defect or disturbance in one, or both, parents. Although some may be homeless as a result of external circumstances (by eviction from a tied cottage for example) others may need considerable help if the family is not to break-up. An arrangement which deprives a feckless mother of a more dependable husband at the crisis of losing the home, or frees an irresponsible father from family obligations, is very likely to make the break a permanent one.

586. The particular contribution of the home help service in preventing family break-up was illustrated in the situation described below.

(9) A mental welfare officer requested a home help to support an inadequate mother while her husband was admitted to a mental hospital as a voluntary patient. The home help established a good relationship with the mother, who not only accepted help with family and household duties and with budgeting, but also confided some of her matrimonial difficulties. After the father's return the family again showed signs of breaking up and the same home help was re-introduced as an alternative to receiving the children into care. In addition to giving the practical help needed the home help co-operated successfully with the mental welfare officer and the child care officer from the children's department, consulting them when there were any danger signals in the family situation, and encouraging the father to find and keep regular employment. This combination of practical help and skilled social work consultation eased the tensions and established the family in a more stable way of life. Arrangements were made by the home help organiser for the home help to visit the family occasionally to prevent any fresh deterioration.

587. The inter-relation of medical and social problems is well seen in families where there is tuberculosis. A typical case was described in a field study.

(10) A mother and several children were all infected. The father abandoned the family on learning the diagnosis, returned when things were better but left again when one child had to return to hospital. The first consideration was to help the mother to persevere with medical treatment by giving practical assistance to keep the home going, but she also depended on the support of the chest clinic social worker in talking out her problems and difficulties. It would also be desirable to

work with the father, if and when he returned, to help him not to run away in the face of difficulties—a common reaction with immature or inadequate people.

588. It is salutory to reflect that the demands made on the health and welfare services, of which these illustrations give some indication, are rapidly increasing. The services for the general classes of handicapped persons have touched only the fringe of the need ; an expansion of all forms of community care for the mentally disordered has been recommended, and the importance of more effective preventive work with families is generally accepted. There is an increased emphasis on all forms of domiciliary and day care for the elderly, even a possible development of the experimental 'boarding out' schemes. We are satisfied that much of the work reaching social workers in the health and welfare services requires a higher level of skill and insight than the untrained worker can be expected to have. Many of the officers whom we met showed a wisdom born of long experience, but they were often the very ones who argued the need for training with the most urgency. Others without a social work training were aware of the limitations of the help they could offer. Even those who set most store by personal experience, and were doubtful of the value of training, said that they would welcome refresher courses or discussion groups, or the opportunity of discussing difficult cases with a more skilled colleague.

(c) *Problems of special difficulty requiring skilled casework*

589. These are often of the most distressing and intractable kind. They will be found in almost any of the social services but more frequently, as we have said, among the severely handicapped, the mentally disordered, and homeless and 'problem' families. There may be specific difficulties, such as lack of housing or employment, which are beyond the power of the services to meet, or an individual may suffer from emotional disturbance of such severity as to have a permanently disintegrating effect on family and social relationships.

590. Examples of this last group include the mentally ill. Very often there is no adequate after-care service in the local authority, or the mental hospital does not refer patients for after-care, sometimes because the local authority staff are known to be overburdened, or insufficiently skilled. The newly discharged patient may then drift until he comes to the notice of some other service, or again to the mental health service, at the point where a precarious adjustment is already breaking down.

(11) A middle-aged man, who was eventually referred to the welfare service for the handicapped, was a registered disabled person who had been unable to work for many years and had recently been discharged from a mental hospital. He was alone all day, as his wife was out at work, and was extremely depressed and despondent. He was quite unresponsive to the welfare officer who was at a loss to know how to make the initial contact necessary to determine what should be done to prevent further relapse.

(12) The mother of a single man recently discharged from a second admission to mental hospital telephoned to the mental welfare officer to say that he was violent and refused to work. She appeared to be an aggressive, accusing woman who resented her loss of income whenever

she had to look after her son. The mental welfare officer could find no clear evidence of delusions or violent behaviour and tried to persuade both mother and son to attend the out-patient clinic. It was clear that the mother required casework help either to accept the son, whom she was trying to push back into the mental hospital, or to make alternative living arrangements for him.

591. An instance in which a psychiatric social worker helped a mentally ill person to attend a psychiatric out-patient clinic was quoted in evidence.

(13) A young man in his early twenties was referred by a general practitioner to the community care service. He had tried several jobs since leaving school but gave them up immediately and finally became quite inactive, refusing to work or to apply for financial assistance. The parents struggled to keep him but their conflicting attitudes towards the situation led to quarrels between them. The psychiatric social worker first saw the parents to hear their version of the difficulties and to enable them to express their resentment and feelings of inadequacy. She then called to see the son who clearly resented the visit, hardly speaking a word. The worker continued to visit as she thought psychiatric help was required. Eventually she got to know the family and was able to discuss their anxieties which led to a considerable lessening of tension. The son eventually spoke of his distress at the situation and it was possible to elicit his mixed feelings about his need for psychiatric treatment, and his fears of what this would involve. In time he was persuaded to attend an out-patient clinic and later agreed to in-patient treatment. The psychiatric social worker needed several months of patient regular visiting to bring about this change of attitude which depended on breaking the deadlock between the son and his parents.

592. The following illustrations show how a serious physical disability may sometimes be less crippling than the strain or stress to which it gives rise, either in the individual concerned or in the family.

(14) A married man suffering from a disease of the nervous system for which he was attending hospital. He was able to move about and was intelligent and alert although his speech was slightly slurred. He listened to the wireless but otherwise did nothing. His wife was very excitable and had recently been in a mental hospital. She was unable to go out alone as she had fears of being hurt, and she could not bear to be alone in the flat fearing that someone might attack her. A home help had been arranged at the request of the hospital almoner but the wife did very little cooking and the couple lived mainly on eggs and milk.

(15) A married man suffering from disseminated sclerosis. He was able to walk but his speech was slurred. The welfare officer had been able to arrange for a home nurse to come in to help with his bath. He attended a hospital three times a week for occupational therapy, and got considerable satisfaction from handicrafts, reading and watching the television. He received continuous care from his family; when his wife went out a sister-in-law came in. He was very preoccupied with his symptoms of which he kept a record. The sister-in-law told the field

investigator of the terrible strain he was causing his wife, keeping her awake most nights, and how they were all almost at the end of their tether.

(16) A single woman whose right leg was partially paralysed but who could get around the house and do a great deal for herself. She had been provided with an indoor propelled chair and an electric tricycle, but had defeated many social and medical services. For months at a time she would stay in bed surrounded by a hot-plate on which she would cook, a wireless, books and a bed-pan. She could not get on with her relatives, or aged parents, and was demanding to be rehoused in a flat of her own. She refused psychiatric help, residential care, and admission to a rehabilitation centre. The general practitioner, almoners at various hospitals and a wide range of voluntary organisations had all tried to help without success. The mental health care and after-care service had been approached but after discussion had decided that the position seemed hopeless as too many people were already involved.

593. The following comments on these three situations were made by the field investigator.

"The conception of a welfare service primarily providing material aids, holidays and diversionary activities does not seem adequate to meet the needs of this kind of client. In all three cases the relationship of the handicapped person with his family needed to be considered and close liaison with the medical adviser seemed essential. In the first case the wife's mental condition needed attention since her disability was largely responsible for the client's total inactivity. In the second case, although the handicapped person received considerable help and was consequently much more active than the first man, the strain on his wife had not been discovered or dealt with. The third case bristles with problems which might well defeat any social or medical service however skilled. It was remarkable that the service for the physically handicapped was the only one which persevered with this difficult client. Although once more the psychiatric problem seemed the central one it had not proved possible to enlist either the help of a psychiatrist or a psychiatric social worker for at least a psychiatric or social diagnostic interview."

594. These were long-standing difficulties. The sudden onset of a severe handicap following an accident or disease, as for example with the newly blind, may also require the type of 'welfare service' referred to above in addition to casework help. It should always be given as part of the casework plan, either by a less skilled worker working with the caseworker, or by the latter. In any event, the caseworker will require time as well as skill in order to build up a relationship between worker and client and to allow the unexpressed difficulties or deeper feelings about the situation to emerge.

595. Some of the more difficult family problems come into this third group, which also contains the 'problem' family itself. In one area, where the local health authority employed trained caseworkers, a visit was paid to a family which appeared at sight to be impervious to help, though it had in fact been kept together for some time by the caseworker's efforts. Another had been helped by the same caseworker to climb up from rock bottom. "I found it incredible", wrote the observer, "in the face of a clean council house with Christmas decorations going up and well cared for children, to read in the record of the caseworker's capacity in the early days to stand by in the face of such vicissitudes as the family burning arm-chairs for fuel, with wet mattresses rotting upstairs and no broom to sweep the floor."

596. Another example of the contribution of a trained caseworker in assessing the focus of difficulty was quoted in evidence.

(17) A family referred by the family doctor for short-term care for the husband, suffering from the after effects of a stroke, to give the wife a badly needed rest. Discussion revealed that a deaf blind son was the focal point of difficulty in the family. The appropriate workers for these defects had, at one time or another, been in touch; he had once been employed in a sheltered workshop but now had no outside contacts and longed to lead a more normal life. His mother was very closely attached to him, and acted as his means of communication with the outside world. Her whole life was taken up in looking after her husband and son and she spoke with distress and some bitterness of how all the workers in turn had tired of the son, labelling him either impossible to help or unco-operative.

It became clear in the course of a series of interviews that the real problem lay in the mother whose protective attitude towards her son covered a great deal of guilt about having had a defective child. She was quite unable to allow the young man freedom to do anything on his own, and although he appreciated his mother's protectiveness he also resented it and demonstrated this in wild outbursts of frustration. In the course of interviews lasting over several months, the mother came to understand that she was in fact impeding her son in making the best use of his remaining abilities and that her own behaviour, whether with him or with the workers from the services for the handicapped, showed clearly why the plans made did not succeed. She asked whether renewed efforts could be made by these workers who were happy to co-operate. One began to take an interest in the young man, visiting regularly to give help in learning to speak and, at the same time, introducing him to a wider outside life, and to a club where he could meet other people with similar defects. He was able, during this time, to go for a holiday where he made friends and began to feel life had opened up in an entirely new way.

597. Social work with the deaf presents particular difficulties. We have become much troubled, in the course of our inquiry, by the isolation of the deaf and the little that is known about the personality development of the 'born deaf' child, and the best way to further social adjustment. We are aware also of the high percentage of deaf persons in mental hospitals and mental deficiency hospitals (see paragraph 280), and that it is fairly frequently said that the deaf tend to be irritable, bad tempered, and suspicious—people who live apart in their own communities, attending the same schools, marrying each other and detached from society as a whole. Some of the evidence from the voluntary organisations for the deaf spoke of a social hunger more intense than anything experienced by hearing persons; others suggested that the deaf are inevitably isolated and that there is no real cure. On the other hand, we have been told that they are good workers with no employment difficulties, at least in time of full employment, and that given a channel of communication their only need is for social activities with others similarly handicapped, and for religious ministration. We have been told that the deaf are dependent upon and exacting towards those who work for them, while in

contrast it has been said that they are more independent than other handicapped persons because they can move about freely and undertake ordinary work in open employment. Some of the individual problems of which we have heard have seemed far from simple. The withdrawn deaf man living alone in considerable squalor, for example, who will not accept help from his family or any other source, the deaf unmarried epileptic mother still under 20 and feared to be promiscuous: the totally deaf married couple whose hearing children are in trouble at school and at home on account of behaviour difficulties: the deaf man in residential care who quarrelled with everyone and one day, looking at his own reflection in the mirror drove his fist with great violence through the glass: the deaf mother with an unstable husband and a large family, unable to budget and threatened with eviction for arrears of rent: the deaf adolescent boy at cross purposes with his family. All these seem to require help from a worker skilled in human relationships, as well as in understanding of and ability to communicate with the deaf. Current inquiries may help to throw further light on the causes and possible treatment of these problems. We hope that local authority officers will increasingly be able to contribute their experience to the sum total of knowledge in this field, and that every opportunity will be taken to initiate or undertake research.

598. Another group which often experience acute social needs are those sometimes described as 'anti-social'. Among them are to be found those who drift in and out of reception centres and lodging houses and frequently come to the notice of welfare departments for one reason or another. If the experience of one large authority is at all typical it seems likely that a proportion of ex-mental hospital patients and some alcoholics make the rounds of Part III accommodation, reception centres, working men's hostels, prison and hospitals without any one service or worker being responsible for long enough to sort out personal or domestic problems or to give constructive help. This group also contains men living in lodging houses who, if they are tuberculous, are often a source of anxiety from the public health point of view. They seldom settle down to treatment and may take their discharge from hospital prematurely and against medical advice. They are often unwilling to accept the restriction and discipline of a rehabilitation centre or tuberculosis colony. The 'difficult' epileptic in this group is frequently out of touch with his family and unable to find work or lodgings where his handicap is understood and tolerated. He, too, may be unwilling to seek help or be considered unsuitable for colony life. Too often there is no alternative for such men to admission to residential accommodation where they are unsuitably placed from their own point of view and may often be disturbing, and sometimes frightening, to elderly residents.

599. In some of the illustrations quoted in this third category of need a substantial improvement could result from good casework; in others only a limited improvement would be possible. In yet others, the prevention of further deterioration, or of ill effects on family, friends or the community would be the most that could be achieved. In describing these situations we are conscious that the trained caseworkers who should be concerned are in very short supply, and have hitherto been difficult to attract to local authority service, though the range and scope of the work should present a challenge to their skill. Obviously there are other considerations to be taken into account; we discuss some of these in Chapter 7. But one important issue is how to

make the best use of such workers. Evidence from the social work organisations suggested that the proper functions of social caseworkers in the local authority have not always been understood and that this had a discouraging effect on recruitment.

600. We discussed the position with a number of our witnesses and, taking into account the various views expressed, we **recommend** that when professionally trained social workers have gained sufficient experience they should normally be used—

(*a*) to undertake initial interviews when the information available suggests there may be a particularly difficult problem, in order to assess the kind of help needed and the willingness of the individual or family to receive it ;

(*b*) to act as advisers or consultants to other social workers in a range of services, and as supervisors (in the sense of teaching and guidance) of newly qualified or appointed social workers, and to assist with in-service training ;

(*c*) to provide a casework service for those needing the most skilled help with personal or family problems which are preventing them from making the best attainable social adjustment.

601. All the field investigators noted the need for well trained and experienced caseworkers to undertake these functions, and some stressed the development which might be expected in existing services if these workers were available. We recognise that there may be difficulties in fitting them into the existing structure of the services but we do not think that these should be insuperable. We discuss this further in paragraphs 698 to 702.

602. We have not referred specifically in this chapter to the functions of different types of officer, though some have been identified in the illustrations, nor to existing specialisation in some services. These matters are considered in Chapter 6 with particular reference to the ' general purpose social worker ' in our terms of reference. Workers in related services play an important part in the total services provided. Some reference to this is made below, and it is more fully considered in Part IV together with other matters of liaison, co-operation and team-work.

Occupational and social activities

603. Many people requiring help from a social worker also need work, occupation, and social activities of various kinds. For some these may be among the most urgent requirements. Training for employment in open industry and the finding of paid work or sheltered employment are outside our terms of reference, but occupational therapy and handicraft instruction are important elements in the services provided under the National Assistance Act for the general classes of handicapped persons and for the blind. Comparable provision is made under the National Health Service Acts for mental defectives and the tuberculous and sometimes also for the home-bound chronic sick.

604. In Chapter 3 we discussed, under the relevant headings, the complementary functions of social workers, occupational therapists, craft instructors and staff of occupation centres. The importance of group activities for handicapped and sick people is increasingly recognised and a considerable expansion and development of these facilities can be expected, especially for mentally

disordered adults. They have an additional value when they include some earning incentives.

605. We have been impressed by the value of clubs, social centres and other recreational activities for those with limited opportunities of meeting and mixing with other people. These help to break down social isolation, and may sometimes be extremely effective as a means of changing attitudes to a handicap or disability. In addition they provide relief for those caring for an elderly, mentally or physically handicapped relative. If social activities are combined with occupation or craft work, and if members can take some responsibility for the general organisation of the club or centre, the therapeutic value is thereby greatly increased. Ideally, this work requires group work rather than casework skill but group workers are unfortunately rare in this country at present. Most social centres and clubs make substantial use of voluntary effort which in itself helps the elderly or the disabled to mix freely with other people in the neighbourhood.

Case records

606. Good social work records are needed in these services. It appears to us that these tend to be poor or non-existent partly owing to pressure of work and lack of clerical help, and partly because their value is not always recognised. We saw a good deal of totally inadequate recording which did not go much beyond names and addresses, as well as some well kept and informative case papers. Both we and the field investigators frequently noted with regret the lack of an adequate social history, or of information on which to base appraisal of a situation or evaluation of progress, or on which a new worker could plan his initial approach to an individual or a family. The whole concept of providing a social work service by the most appropriate officer or department breaks down if records do not contain basic data and significant facts. Insufficient information affects the department concerned as well as officers in other services which may be called in. It also makes it impossible to evaluate the service given or to work out, follow through and test the effect of any consistent course of action. We **recommend** that every effort should be made, firstly to encourage better case recording and secondly to establish procedures (where these do not exist) to enable records, or an adequate summary of relevant information, to be made available to other departments and to professional colleagues. It is particularly important that safeguards should be established whenever confidential information is involved ; we **recommend** that local authorities should consider and review the way in which such papers are handled within departments. During one of our visits we passed through a general office also used by the public for inquiries. We saw papers relating to an unmarried mother (whose name and status was clearly visible in the heading) lying in a correspondence tray close to the public inquiry desk. In another instance we found case records were kept in unlocked filing cabinets in the general office. These may have been only isolated instances of neglect or failure to safeguard records, but since so much intimate and confidential information is in the keeping of health and welfare departments we consider it desirable to draw attention to the need for special care. We consider this question of safeguards further in paragraph 1090 in connection with the work of co-ordinating committees and case conferences, where we also recommend that local authorities should review current practice in this connection.

Chapter 5

SOCIAL WORK AND THE HEALTH AND WELFARE SERVICES

607. Having surveyed the needs of those who are covered by our terms of reference and some ways in which these are met, we now turn to the contribution of social workers in realising some of the objectives of these services. A social work service includes the framework and process of administration, the provision of practical assistance and the skill and sense of vocation of the staff. We shall therefore in this chapter discuss the personal and social consequences of being in one way or another handicapped and the aims of a social work service in mitigating these consequences. This will lead to a consideration of the nature of social work as it has been presented to us in evidence and the varying degrees of skill that may be required in different circumstances. This will, we hope, help to clarify the rôle of social workers in relation to that of other closely related workers who also have a 'social' element in their functions.

Problems of isolation

608. Social isolation has been correctly interpreted as one of the chief hazards from which severely handicapped people suffer. Attempts have therefore been made to bring them into a community, and to give them, through group activities, some companionship with their fellows coupled with pleasure in interests and recreation. At the same time, it may be questioned whether some of this provision, particularly for the blind and the deaf, has not tended to isolate them. Possibly, in addition to providing special activities, greater efforts should be made to help them to do things with and like other people. Severely handicapped people themselves often resent their segregation, though they may also fear wider contacts and the continuous effort required of them to help other people to adjust to their handicap. In a report of a week's residential holiday for deaf blind people run in 1957 by the Southern Regional Association for the Blind, it was noticeable that the essays they wrote afterwards all described the pleasure of going to a restaurant and having morning coffee, " just like anyone else ", as they said. We give this simple illustration to show the value for even severely handicapped people of being helped to move out into the ordinary world to the extent that this is possible. At the same time, we would add that it has seemed to us from our visits that the activities in handicraft centres and clubs are of the greatest possible importance in lessening isolation by providing opportunity for talk and discussion within a group where each member is accepted. This is an event to which to look forward, a chance to exercise the abilities which are not damaged, and thus to experience a sense of achievement through making things or through dancing, singing, playing games, making friends and so forth.

609. In visiting and otherwise meeting many handicapped people during the course of our inquiry, one of the things which struck us most forcibly was the frustration which must accompany the constricted freedom that comes from loss of a sense, a limb or physical mobility, and thus the damming up

of energies normally discharged through one or other. At the same time, a great deal of unpleasurable effort has to go into doing what others do comparatively effortlessly. We therefore regard all means of increasing mobility, of giving outlets for energy and forms of companionship which are satisfying to individual handicapped people, as fundamental to their welfare. Amongst these, we would include household adaptations and aids, cars for the disabled, radio sets, talking books, and other devices and means of activity. None of these should, however, be introduced unless it will be helpful to and welcomed by the individual person concerned.

610. It was frequently suggested in evidence that people suffering from a particular handicap had quite different characteristics from those suffering from any other handicap. Such evidence usually came from those who only had experience with one group of handicapped people. We understand and sympathise with this view, since those who expressed it were so conscious of the impact of tragedy in each handicap. Nonetheless, we doubt whether to be blind or deaf is in fact 'better' or 'worse' than to be severely crippled and helpless, while at the same time remaining mentally active. In any event, we find it difficult to believe that personality development and functioning would be affected in quite different ways according to the type of physical handicap. Children born severely or totally deaf raise certain different considerations, to which we have referred (paragraph 291). Apart from this, we think that handicapped people are more likely to suffer from loneliness, a feeling of being different or unwanted, and to experience more frustration and the need for greater effort in moving out into the world with confidence and freedom; and so to face greater hazards in making a satisfying adaptation to life (particularly in marriage, parenthood and work) than people not so handicapped. Taking this into account it seems to us that the range of psychological reactions to physical handicap is the outcome of the particular personality and life experience of the individual, and is not different in nature from human reactions to other stress-producing situations or hazards. The emphasis in all social work with the handicapped should be on people who are handicapped rather than on handicapped people. The primary thing about them is that they are people with the same needs and desires as others, who are sometimes partially or wholly frustrated in fulfilling these needs because of their handicap. The aim of social work with them, as with anyone else, is to use varied means to make it more possible for them to satisfy, so far as may be, the basic human need for love, achievement, recognition, a stake in the community, and a purpose to life.

Personal, family and social adjustment

611. So far, we may have appeared to speak as though handicapped people lived in a vacuum and were all of one age. In fact we think that it is of vital importance to consider the handicapped person's place in the ebb and flow of family and social relationships, and to realise that the ways to satisfy their human needs, like those of anyone else, differ considerably during the seven ages of man. We have found during our inquiry too litle appreciation of the strains imposed by a severely handicapped member on the family and the consequent effect on family relationships. For example, where a child is born physically or mentally handicapped it is

not unusual for the parents' feelings of guilt or anger to express themselves in over-protectiveness, or in rejection of the child. This will affect both him and the other children in the family. 'Welfare' visits tend to be concentrated on the handicapped person himself, and workers sometimes show too little appreciation of the strain, particularly on the mother, of the constant extra work and attention which he may require. This strain can lead to mounting tensions, which may affect a marriage and have its ill effects on the whole family life unless attention is paid to the total situation and ways considered to relax the strain. For example, mothers are often much confused about the best way to handle various situations with handicapped children and adolescents, and may be further confused by conflicting advice from neighbours and others.

612. The personal, family and social adaptations required may be quite substantially different where someone whose physical development was normal becomes handicapped through accident or a disease process. The effect will be different according as the onset is slow or sudden, whether it takes place in a young person or an old person, in a single person or the breadwinner or mother of a family. It is now generally recognised that all forms of severe separation or loss, whether of a loved person, or a limb, or sight, or hearing or one's home tend to lead to a period of withdrawal which may sometimes be manifested in severe and prolonged depression. For example, the depression and refusal to get up, 'life is ended' feelings which sometimes accompany blindness are well known.

613. A whole family's way of life may be affected by the permanent physical disablement of one of its members or by the onset of mental illness. The concern for the handicapped member may be accompanied by anxieties about the future, and fear that it may not be possible to make all the adaptations necessary to preserve the family's way of life. The effect of such fears are likely to be particularly damaging to the children, perhaps most of all where the father or mother begins to show the changes of behaviour symptomatic of mental illness and finally goes to hospital, but for a parent to become suddenly blind or deaf or crippled may be no less disturbing to a child's world. The handicapped person himself, or herself, in such circumstances is in the conflicting situation of experiencing a natural deep-seated need to mourn and be comforted, to become dependent and be looked after, at the same time that other members of the family are also suffering from repercussions of shock and fear, and are therefore themselves experiencing the same need for help and comfort (in the old sense of strengthening rather than the modern sense of bright reassurance which does not reassure).

614. In such circumstances, the whole equilibrium of the individual's life and that of the family in its relationship to that person has been upset, in the same way that the homeostasis or balance of the body has been violently disturbed. Medical intervention is directed towards helping the body to achieve a new homeostasis. This is not something which happens in isolation from the attitude of the person himself to the physical condition; one man will turn his face to the wall and wish to die, another will put forth disproportionate extra effort to compensate for his physical handicap. Sometimes the pendulum may swing too far. In any event, the reactions and motivation of the handicapped person will be intimately related to those of

the other members of the family group, who are all struggling, or refusing to struggle, to restore a disturbed way of life to a new equilibrium. It is unnecessary to expand on their similarly disturbed social adaptation, the effect on work, on ability to do things with other people, the possible fall in the family's standard of living, of child care and so forth.

The functions of social workers

615. In the light of these considerations, we regard the essential functions of social workers in the health and welfare services as being to assess the disturbance of equilibrium in a given handicapped person and in his family and social relationships so as to give appropriate help. The aim will be to offer a supporting relationship in which his and their practical needs, as well as their fears, frustrations and anxieties, are understood and means used to meet or lessen them, and also to further a better personal and social adjustment, and a renewed ability to exercise responsibility, by whatever means are indicated for a given person at a given time. This may often include supplying information and relevant services or concrete help as and when these are needed. We would stress here that the activities we are describing may be simple and straightforward in some instances but complex in others. Our concern is that in all health and welfare departments there should be social workers sufficiently well qualified for thorough initial and subsequent assessments to be made of the needs of each individual and the extent to which these can be met by a social work service.

616. In short, the purpose of social work as we see it is to help the individual to achieve the best possible personal, family and social adjustment. This will include trying to bring about any necessary improvements in the environment. We have distinguished between personal, family and social adjustments. These are all closely interwoven but it is possible nonetheless to isolate different elements and to intervene at the most appropriate point in the individual case (a 'case' is a situation, not a person). Thus severe physical handicap may occur in someone with a well integrated personality and normal family set-up. In such circumstances the main help needed may be in dealing with the initial shock and with the necessary practical adaptations in living. To break down the total problem of adjustment into its component parts and help the person and his family to see how they could cope with it may be all that is required. In other instances, where, for example, the person is immature and demanding and where there is less strength in the family relationships, much more support, given with greater skill and for a longer period, may be called for. In other cases still, the handicap may occur in someone who already had personality difficulties or who was able to lead a satisfactory life previously but who lacks the inner resources to master the effects of the handicap. These same inabilities to meet misfortune may also occur in someone else in the family as a result of the disturbances caused by the handicap to the family's way of life. For example the shock, coupled with the attention lavished on the handicapped person himself, may cause another member of the family to become more demanding. Many handicapped people will also need help to accept a greater degree of dependence on others, to come to terms with the added burden they must sometimes impose and not to become more dependent than they need.

617. Social work is directed towards helping individuals and families to cope with their problems and so to achieve at any given time a better personal and social equilibrium, a better chance to face challenges and accept responsibility, than they are able to reach without help. It is in essence a supporting relationship, an extra prop to those who have lost a balance, to help them to regain it. The art of the social worker lies in his use of this relationship and his ability to hold and merit the client's confidence. This means doing things with people rather than for them, not making them dependent but accepting the dependence necesary at a given stage in their disturbed life balance in order that they may be enabled as a result to stand on their own feet again, psychologically speaking, to the extent that lies within their capacities. Some people, particularly those who are or have been mentally ill, may need this support for a very long time, possibly at intervals all through their lives. But to walk with support is better than not to walk at all. The metaphor is perhaps ambiguous at this point, because it is necessary to distinguish between those cases which are 'hopeless', in that no cure is possible in the present state of our knowledge, but where some alleviation or adaptation can be achieved with help, and those where almost no improvement in the person or family is possible, but yet some improvement can be brought about in the situation as a whole by lessening external pressures or by increasing community tolerance. This increase of tolerance applies particularly to 'problem' families, though it is unfortunately true that almost all forms of physical or mental disability lead to varying degrees of avoidance, or to discomfort in the presence of the handicapped person, however much compassion some forms of handicap arouse.

618. It may well be objected against much we have said that very many people suffer from disturbances in their life adaptation and have to make, and would want to make, adjustments themselves without the help of social workers. This is both true and, when the adjustment can be satisfactorily made, desirable. The factor of time and timing is, however, of primary importance in all social work. The old saying about 'time the great healer' indicates that the living being does come to terms with the shock of loss or deprivation. The real case for social work intervention in this natural process of adaptation is, however, that time is not always on the side of the angels, with the result that if family and personal disturbance is more prolonged than it need be it may have secondary damaging effects which might have been prevented. For example, it is well known that unless a newly blinded or otherwise disabled person is quickly helped to gain confidence through doing things in new ways it may be difficult or even impossible to foster this confidence later. Whether or not to do so requires a high degree of skill in the worker will depend on the particular case.

619. The essential task of the social worker in helping the individual to establish a fresh equilibrium is thus to know where he and his family are feeling the pressures most and what can be done to relieve these. This means not only supplying necessary services but also knowing enough to be able to do and say those things which help to lessen fear, anxiety, hostility and frustration so that confidence and hope may have a chance to grow. Sometimes this may be achieved in quite simple ways: at other times it may be a skilled process because it may involve sufficient knowledge of

human behaviour and of conscious and unconscious motivation, as well as of socially determined attitudes, to make a reasonably accurate assessment of the personal and family strengths and disabilities in a particular case. It always calls for the ability to make a helpful relationship with the person concerned, and to stimulate him to take action to meet his needs, to the extent that this is possible with any necessary help. This means the formulation of a plan, based on an assessment of the situation and aimed at achieving the best possible social and personal improvement in a particular case. In long-term cases there may of course be substantial periods when no action beyond steady support is possible. In many, too, the best that can be done may be to prevent further deterioration in a situation, or to help people and their families to accept inevitable physical or mental deterioration and strain.

620. This whole social work activity requires skill in helping people to talk about their fears and anxieties which they are often reluctant to express to others, or even to formulate to themselves. This is particularly important with handicapped people, who are often putting on a brave front to others but who badly need to be able to talk about the hopelessness and despair with which they may be struggling alone. We have already referred to the strong verb 'to comfort', meaning to strengthen, having degenerated into bright attempts to reassure, to minimise, or to divert by inadequate means. This is the natural reaction by which many people ward off the full impact of suffering in others. It is, however, no real comfort to the one who suffers. It is often objected that it is much better to try to cheer people up than to let them dwell on their misfortune. This runs counter to old wisdom about 'not bottling things up inside', 'having a good cry', 'feeling better after getting it off one's chest'. Modern psychological knowledge reinforces this view that fear, anxiety and frustration are in fact lessened by being expressed to someone who understands, whose confidence is a source of strength and who is not personally involved as family and friends would be. This calls for skill in helping people to talk about painful things, or small things which may loom large to them, as well as ability to listen sympathetically and to nourish hope and confidence. This sounds easy but in fact may require very considerable skill. These aims are accomplished partly by respect for the person, understanding of him and belief in his capacity to make a better life adjustment. This is likely to communicate itself to him, and make him more able to talk about what troubles him, as well as more confident, and thus more free to make choices about his life. It may often be necessary for a social worker to be concerned with some other member of the family, as well as with the handicapped person himself, in order to bring about this better adjustment. For example, if those on whom the main burden falls can have a good 'blow off' to the worker every now and then about the difficulties of the situation, knowing that their side of the problem is understood, it is less likely that irritation will flare up to the handicapped person himself, particularly if it is also possible to take practical steps to lessen the burden. Work with other members of the families of mentally disturbed people, or where the parent of a handicapped or defective child is either rejecting or over-protective, is particularly important.

621. Social workers have to learn not only to ask for and give necessary information fully and patiently but also to listen and simultaneously to assess

the significance of what is said or not said, and to relate this to previous knowledge of the person and his situation. Sometimes, too, with certain disturbed people, the skill may lie in helping them not to talk, that is, to strengthen their defences against the flood-tides within. In any event, the most difficult stage lies in making it possible to go on, with help, to find constructive ways of dealing with the problems and fears which they have begun to express to the worker. At this and other points, social workers must also be aware of all available statutory and voluntary services which could give the most appropriate help at any given time.

622. The real purpose of such services, as we see it, is that they should be appropriately used in individual cases at the right point in time in order to strengthen the person through the exercise of his abilities, through increased physical mobility leading to a change of scene, and through group activities which meet a natural human need for companionship outside the family. Individuals may need other services, such as those supplied by the health, welfare, education, children's and housing departments, by the Ministry of Labour and National Service, the National Assistance Board, and by voluntary organisations. It is therefore important for social workers to be well versed in what is available, to use this knowledge appropriately, and to be able to give accurate information about other services. It is also essential that they should understand the functions of other workers and should work in partnership with them.

623. What we have already said about the social worker's function in accurately assessing a personal, family and social situation from the point of view of the help that might be given to bring about improvements (often in circumstances of stress), indicates that social workers will in the course of their relationship sometimes have to help people to talk about those things which are troubling them, if they wish to do so. For this and other reasons they may know intimate details of peoples' lives. This material may be germane to social remedial action on the case; it may therefore properly be discussed with or passed on to colleagues, usually with the knowledge of the person concerned. It will also be necessary to embody some of it in the case record in order to watch the progress of the case. But beyond this, the strictest preservation of confidence is called for. We believe this principle is already accepted in regard to psychiatric social workers and almoners. We think, as we have said in paragraph 606, that it should apply to all social workers, so far as divulging information and safeguarding records are concerned. We refer to this again in Chapter 12 in regard to procedure at co-ordinating committees and case conferences. In any event, no information should be sought which is not relevant to the help which might be given. There is no right to indiscriminate history-taking or discussion of a case, which may sometimes be a polite name for vulgar curiosity.

Knowledge and skill required by social workers

624. Some of the work we have described could be done without prolonged training where well-adjusted people in a normal family set-up are concerned. Much more skill would be required where there are greater disturbances of ways of living or more complex family problems. Our description of the nature of social work, as we see it, with physically handicapped people would apply equally to the same work with mentally handicapped or disturbed ill, or elderly people and their families, and also

to homeless and 'problem' families and unsupported mothers, though there is likely to be a higher proportion of problems in all these groups. Work of the more difficult kind necessitates knowledge of unconscious motivation and the irrational elements in behaviour. More knowledge of pathology is needed with extremely immature, inadequate or psychopathic people, as with those suffering from neuroses or psychoses. More skill may be required to help any of these to make a better personal, family or social adjustment, and their capacity to do so may be very limited. Their ability to form or sustain constructive relationships may be severely impaired, and they may have only a limited capacity to meet socially acceptable standards of behaviour in work, spending habits, relations with neighbours, and family obligations. This means that individuals in these groups may often and necessarily become dependent on the social worker, who must act in relation to them like a wise and dependable parent, encouraging them to make the choices and decisions of which they are capable but holding them to the necessity to meet social obligations, and at the same time assuming for them responsibilities beyond their capacity to shoulder. It is in this sense only that authority can properly be used in social work in order to protect immature, inadequate and disturbed people from those decisions which are too big for them to make realistically, and from consequences which they could neither face nor control. This is quite different from suggestions that authority should be used to go into people's homes and 'clean the place up' without their invitation or consent, or indeed to make any decisions about the conduct of people's affairs for them rather than with them. We think that complaints about people being made dependent and about social workers being 'snoopers and do-gooders' often spring from such practices, which are in our view quite contrary to the spirit of social work. It is, we think, essential that social work should be conducted with respect for and courtesy to all human beings and a sense that their well-being matters, however old or ill or feeble-minded or handicapped or socially outcast they may be.

625. It is important in casework to offer a dependable relationship. This naturally means that one social worker should be in charge of the case and have a continuing responsibility for it. It also calls for a degree of knowledge and skill of a quite different order from coaxing people or telling them to pull themselves together. The 'try everything once and see what happens' approach is of little use and may be actually damaging, besides being wasteful of public funds.

626. We recognise the importance of the friendly visit and chat, which may play an important part in many lonely people's lives. It should, however, be related to sound knowledge about the person's needs and family situation at any given time. For example, it is not really helpful to have a friendly chat with a crippled old lady and do nothing about her daughter who is breaking under the strain of caring without remission for her needs. Any particular visit may well be for the purpose of seeing that everything is as right as it can be, but it should be paid by officers sufficiently trained to detect if it is not.

627. In social work there must be study of the situation, assessment of the need, and a plan (which may be amended in the light of developments) as to how the need is to be met by the use of the methods previously discussed and for the purpose of enabling the person concerned to become more

confident and socially effective in the management of his affairs and the solution of his problems. It is the improvement in people's ability to cope with their difficulties, with the use of such material benefits as may further this purpose, which is the aim of social work. The means used must thus be appropriate and adequate to achieve the end in view. We cannot do better than quote the comments of one of our field investigators on this point :—

> "Social work then includes within it all kinds of services of which casework is one. It may be quite possible to administer welfare services without casework if the client falls within a well-defined category of need and if he is not so confused or disturbed by his feelings as to prevent him making use of them. The majority of clients using local authority services probably can get along in this way for most of the time. Some, however, all the time and others occasionally may need the extra help that casework can give. If there is to be a continuum of good social work from referral to closing, or following up and closing a case it ought to be someone's job somewhere along the line to say:—
>
> (1) What is the nature of this problem?
>
> (2) What is the motivation and capacity of the person or family dealing with it?
>
> (3) What opportunity that is, what kind of service, ought the local authority to give them to solve the problem?
>
> Ideally there would be the kind of spirit in a department and the kind of attitude in the workers which would lead them all to ask such questions—and to realise when the straightforward service was proving inadequate and more help was needed. Unfortunately, at the moment, because of the prevalence of different kinds of training and experience and because of sheer necessity, there being often no other resources available, workers perform their own function and make up for their lack of casework skill by exhortation, good advice, perhaps, occasionally, a ' good telling off ', or, if all else fails, by writing off the family or person not as someone possessing a problem but who *is* a problem.
>
> I think there is a social work ' attitude ' which should ideally prevail throughout a department—an attitude of acceptance of people in trouble and a desire to use every possible resource in helping them. This would include the recognition that not everyone automatically possesses casework skill. Some people learn it by long experience."

628. We agree that this attitude should prevail throughout a department. As we have said elsewhere, we think that the rank and file field worker should be backed by administrators, advisers and other workers whose knowledge and skill may be required. It is this total body of professional skill and experience which should constitute the service available to any given client according to his need. This social work service will itself be only part of the range of services available under the general direction of the medical officer of health. Where the welfare services are separately administered social work will form a major part of the service provided.

629. So far, casework, that is social work with individuals, is the only method which has begun to reach a satisfactory stage of development in this country. We shall refer later to the desirability of using skill in group relations as a form of social work in centres for the handicapped, in clubs for mentally disturbed people, in temporary accommodation, in hostels of various kinds, and in homes for old people, as well as in the work of home help organisers. We think that if some social workers had had a training in group work much more could be done to help people within our terms of reference, and their families. Training in community organisation would be valuable to officers with administrative responsibilities in enabling them to identify unmet or inadequately met social needs and to help to mobilise

local community resources to meet these needs. Some of the scientific study and action research in relation to 'problem' areas beginning in this country and elsewhere will also, we hope, in the long run bear fruit as an element in more advanced social work training. In any event, we think that knowledge derived from social work with individuals, groups and communities should also be used in planning and starting social centres, residential homes, holiday camps and the like.

Why social workers need training

630. The growth of knowledge, even in the last decade or so, in sociology, psychology and psychiatry, has made possible a deeper understanding of the different groups of people within our terms of reference, and has therefore also made possible more consciously directed and effective work with them than heretofore. Some of this knowledge is now widespread among the general public, for example, the effects of maternal deprivation or of continuing stress in the causation of physical ill-health. In these circumstances, the public demands a higher standard of service, which, in the context of our inquiry, means that the social work services in health and welfare departments should be staffed with trained and experienced social workers, able to call on the services of welfare assistants for straightforward work. In our view, knowledge from the social and behavioural sciences is also required by administrators at every level in the services. This calls for continuing study if new knowledge in the fields in question is to be translated into policy formation and practice, as has happened long since with knowledge in the medical field. It also calls for regular means to make use of the experience of field workers, a constant awareness of points in the service at which change or improvement may be required, and a sensitivity to the consequences of social change as these affect in varied ways the lives of handicapped, old and disturbed people.

631. In our view social work with physically, emotionally, mentally or socially handicapped people and their families calls for knowledge and skill, as well as attitudes of respect for rights and liberties. We think that systematic social work of this kind would save some undirected effort, which produces little result and may indeed even permit preventible damage to happen. We also think that it would not only add to human welfare, which is its primary aim, but would also make it possible for some people to function with a higher degree of social and economic adequacy. Furthermore we are convinced that good social work is an essential corollary of earlier discharge from mental hospitals to out-patient treatment, with all the problems of personal, family and social adjustment which will accompany this, desirable though it may be for other reasons. Moreover the personal and social problems and needs which we have described are found within all income groups of the population. We thus hope that in time the social work services of health and welfare departments will be used by all who need them irrespective of income, class or occupation.

632. Social workers primarily need knowledge about family life, human development, needs, motivation and reactions to stress situations; as well as about the effects of social and economic circumstances, attitudes, values and expectations on individual behaviour. They also require a good knowledge of the public and voluntary social services which have been brought

into existence to meet varied needs, as well as a sound working knowledge of good administration. The skill which it is essential for them to have lies in the ability to apply knowledge in the use of social work method. To acquire sound knowledge and to develop necessary skill requires training of sufficient length to enable theory and practice to become integrated with each other. Neither theory nor practice by itself is sufficient to produce the results we have described. The special contribution of caseworkers is made by means of an informed understanding which covers emotional needs and unconscious factors, and skill in using this professional relationship to help clients, at the right moment and in the right way, to make their own progress step by step, and so to move towards a renewed and strengthened independence. This work requires training, self-understanding and high professional standards. The social worker must be able to see any given problem in perspective with perception and a realistic awareness of the possibilities and limitations of treatment. He needs this support both to give help effectively and also to accept that sometimes damage or deterioration is irreversible.

633. In stressing the necessity for systematic training, we wish at the same time to pay tribute to the work of those who have learnt 'on the job.' Many of them have a wisdom born of fellow-feeling and long experience, and much that has been said in this chapter will be familiar to them. Nonetheless we think that training is necessary in order to speed up learning, to give workers the use of a wider range of knowledge and skill than they could possibly develop on their own and, by teaching them an orderly working method, to enable them to understand the real need in a situation at a given time, to meet it with more sureness of touch, and with increased ability to know why they succeed or fail with particular people or in given circumstances. We also think the selection of candidates on grounds of personal suitability and the inculcation of professional ethics are essential.

Social work in relation to other professions

634. We are very far from suggesting that social workers have any monopoly of helping people to achieve a better adjustment between themselves and their circumstances. The complexities of human nature in its physical, mental, emotional and social aspects are such that various professional skills are involved, often in combination with each other. The point or points of intervention should obviously be where they will be most effective. The restoration of or improvement in ability to function acceptably is a common endeavour of medicine, education and religion as well as of social work. This is also one of the reasons why team-work and referral are now regarded as a necessary part of successful work in these fields.

635. It is becoming accepted nowadays that, because they work directly with people, those who practise these various professions need to have some common knowledge about human relations and socially caused attitudes and values. It is also accepted that it should be the main function of psychologists, psychiatrists, sociologists, social anthropologists and social workers to use this knowledge by the specific working methods which are being evolved for each of these professions. In view of the fast growing complexity and scope of modern knowledge no one profession dealing with a range of human needs can make exclusive claims in relation to the others. Each has its

essential function as well as its necessary overlap with others. This overlap is indeed required for intelligent co-operation and team-work. It should also enable a holistic approach to be made to the multiple needs of man.

Classification of need from the angle of social work

636. At the same time, questions of appropriate diagnosis and remedial action may arise when more than one profession is involved. We have already said that we regret the tendency to isolate different groups of the handicapped for special—and often separate—welfare provision. We have shown that this happened historically because different social reformers became concerned with particular types of need, or because classification is made along medical rather than social lines. The effect has been to classify people according to their age grouping, handicap, or social failure. These categories are logical for certain purposes, for example, national insurance or specialised medical treatment. They do not, however, necessarily provide appropriate groupings when it comes to social work. People whose circumstances and personalities may differ widely will be found to have a limited number of emotional needs and responses, even though their predicaments and problems may be very varied. The simplicity or complexity of individual, family and social problems will therefore not necessarily coincide with the classifications of medicine or the social services. A higher degree of professional training and experience is needed to help in some situations than others. We recognise that some social workers prefer to work with people suffering from particular disabilities, for example, the physically handicapped or the mentally ill ; others prefer a more varied case load.

637. The point we wish to make here is that the personal needs of people suffering from varied handicaps remain the same. This was in fact recognised when unrelated voluntary effort on behalf of different groups of handicapped people resulted in the same services : employment, occupation, companionship, and spiritual ministration. We are thus suggesting that this fact of common human needs should be more clearly recognised. We think the query ' aren't we all social workers? ' comes from the perception that social and personal aspects must be borne in mind in meeting any specific need. We fear this is often lost sight of through concentration on a single aspect of human need. Doctors, health visitors and teachers all work in the social sphere, because in order to fulfil their proper task they too should have knowledge of individual motivation, family relationships and social circumstances. Similarly, social workers help to promote health and education, though this is not their primary function. In spite of these common elements we think it is less confusing to reserve the term ' social worker ' for persons qualified and used to perform the functions we have outlined in this chapter. In saying this we have no wish to deny the individual and social element in the function of teachers, doctors and health visitors.

Definitions

638. It is common practice to begin or end with a definition. So far as casework is concerned, we think we cannot do better than quote the definition submitted from this country in connection with an international terminology study. It runs as follows.

> " Casework is a personal service provided by qualified workers for individuals who require skilled assistance in resolving some material, emotional or character problem. It is a disciplined activity which requires a full appreciation of the

needs of the client in his family and community setting. The caseworker seeks to perform this service on the basis of mutual trust and in such ways as will strengthen the client's own capacities to deal with his problems and to achieve a better adjustment with his environment. The services required of a caseworker cover many kinds of human need, ranging from relatively simple problems of material assistance to complex personal situations involving serious emotional disturbance or character defect, which may require prolonged assistance and the careful mobilisation of resources and of different professional skills."[1]

Group work as a form of social work is directed towards giving people a constructive experience of membership in a group so that they may develop further as individuals and be better able to contribute to the life or the community. Social work with communities is primarily aimed at helping people within a local community to identify social needs, to consider the most effective ways of meeting these and to set about doing so, in so far as their available resources permit.

Chapter 6

THE 'GENERAL PURPOSE SOCIAL WORKER': PATTERNS OF FUTURE DEVELOPMENT

639. In Chapter 4 we classified the needs of those using the services with which we are concerned into three groups, (*a*) straightforward (*b*) more complex (*c*) specially difficult. We suggested that three degrees of skill and qualification are required by social workers in meeting these needs. In relating these conclusions to the structure of the services we must first consider the second part of our terms of reference, namely " whether there is a place for a general purpose social worker with an in-service training as a basic grade ". We have accordingly examined existing specialisation and considered how far it is justified, whether it should be retained, reduced, or otherwise modified, and what degree of grouping of existing functions is either possible or desirable. Our general findings indicate that less sectionalised social work in these services could provide a better service and make more profitable use of the resources available. We have also noted the current trend towards a generic training in casework, that is to say social work with individuals no matter the particular setting in which it is practised.

640. Appreciation of the common social and personal factors in the needs of those using the services is a first and vital consideration. There is always a risk in any type of specialisation of concentrating on a particular aspect at the expense of the whole. We ourselves have seen how this can lead to a focussing of effort on a particular need or handicap, rather than on the effect of these on the individual in his family and social setting. Our inclination is thus away from specialisation so far as social work is concerned and towards some combination of functions, subject to certain necessary safeguards.

[1] The International Conference of Social Work is preparing a glossary in several languages of social welfare terminology. This quotation forms part of a provisional definition of casework.

SPECIALISATION IN SOCIAL WORK IN THE HEALTH AND WELFARE SERVICES

641. A primary difficulty in any consideration of specialisation in the health and welfare services is the use of the words 'specialist' and 'specialised' to embody two distinct, and largely contradictory, concepts. The point is best made in relation to training where 'specialised training' may refer either to a narrow and limited course, or to advanced qualifications following a general training. In this inquiry we have been concerned with specialisation in the sense of services which are in effect separate sections of a department, separately administered and staffed solely or mainly by officers engaged in that one service. Such are the mental health and tuberculosis services, the services for unmarried mothers, the home help service, services for the blind and deaf, and, to a much lesser extent, for homeless and 'problem' families. Historically speaking, the majority of these services developed piecemeal as recognition of a particular need resulted in the provision of services staffed by workers with a special function and, in some instances, a special training. Existing specialisation is thus largely an expression of historic development, influenced to some extent by concentration of need in densely populated areas.

642. Some of these specialisations also follow the lines of medical diagnosis. This is entirely logical from the point of view of providing appropriate medical treatment and care. It should however be recognised that, as we have said, related social diagnosis and social remedial action will not necessarily fall into the same grouping. We think that lack of appreciation of this point accounts for much of the existing division of opinion about specialisation in social work.

643. The position at 1st May, 1956, in the services with which we are concerned is summarised briefly below.

The mental health service

644. About 60 per cent of the officers within our terms of reference in the mental health service had no other duties; there was some specialisation within the service between the statutory duties of certification and removal, the prevention and after-care of mental illness, and the mental deficiency service. Twenty-eight of the 31 psychiatric social workers employed by local health authorities were engaged solely in care and after-care of the mentally ill, 2 in addition undertook work with mental defectives, and one also acted as a duly authorised officer. In addition 12 were shared with hospitals. Some local authority psychiatric social workers also advised on the mental health aspects of social problems in related services.

645. Mental welfare officers had a wider range of functions than psychiatric social workers. Many, as we have seen, combined mental health duties with duties as welfare officers under the National Assistance Act, though practice varied between different countries and between different types of authority, as shown in Table 26. In English and Welsh county boroughs the mental health and welfare services were almost always staffed by separate officers; in Scottish counties the mental health service was provided by welfare officers, while an intermediate degree of specialisation was found in English and Welsh counties, and in large burghs in Scotland.

Table 26: Percentage of mental welfare officers (excluding assistants) who also undertake duties under the National Assistance Act, 1948

Type of authority	All three countries	England	Wales	Scotland
All authorities	41	29	66	96
County councils	55	43	75	100
Councils of county boroughs and large burghs	11	6	0	77

646. Within the mental health service about 30 per cent of mental welfare officers undertook the full range of duties. At the other extreme about 10 per cent (employed mostly in the larger county boroughs and in London) acted solely as duly authorised officers and rather over 10 per cent worked only with mental defectives. The evidence regarding this service and our proposals are discussed in paragraphs 668 to 673.

Services for the care and after-care of the sick

(*Tuberculosis ; after-care of patients referred for social work by hospitals or general practitioners ; venereal disease.*)

647. Almoners, and other social workers without an almoner's training, are employed in each of these services (and also in the care of unmarried mothers) in some areas. In others the duties form part or all of the work of health visitors. The degree of specialisation among social workers is shown in Table 27, which is derived from Table 8. The evidence, and our views, are referred to in paragraph 674.

Table 27: Percentage of almoners and other social workers in the after-care services with a range of duties under the National Health Service Acts

Range of duties	Almoners registered with the Institute of Almoners	Other social workers who have not taken an almoner's training
Tuberculosis only	45	55
Venereal disease only	6	15
Unmarried mothers only	—	10
Venereal disease and unmarried mothers ...	6	2
Specified duties (total)	57	82
General, whether including the above or not	43	18
Total	100	100

Social work with homeless, 'problem' or other families

648. Social work with families is not generally regarded as a specialised service in the sense described. A wide range of staff may be concerned—welfare officers and other social workers, the home help service, and health visitors. A small number of authorities have appointed trained social workers to undertake intensive casework with selected families ; these are usually referred to as family caseworkers or family welfare officers. We discuss the evidence and make proposals in paragraphs 675 to 676.

The home help service

649. The post of home help organiser is usually filled by officers with no other functions, though welfare officers act as organisers in 2 English, 2 Welsh and 10 Scottish counties, and in 8 large burghs in Scotland. The service is provided by the Women's Voluntary Services in a few English authorities. In addition, 30 superintendent health visitors or nursing officers were recorded in the questionnaire as undertaking the duties of home help organiser. The evidence on this service and our suggestions are referred to in paragraphs 677 to 678.

Domiciliary and residential care of the elderly

650. Like social work with families, similar work with the elderly is not specialised but in a few areas it forms part, or all, of the duties of an almoner or other social worker in the health department. Generally speaking, a range of staff similar to that mentioned in paragraph 648 is concerned with the care of the elderly in their own homes. Welfare officers under the National Assistance Act (and residential staff) have responsibility for those in need of care and attention, and for liaison with various voluntary services. These arrangements are discussed further in paragraphs 679 to 681.

Services for the handicapped

(a) *The blind and partially sighted*

651. The services for the blind have hitherto been entirely specialised and staffed by home teachers of the blind who rarely have other functions. We have indicated (paragraphs 511 and 523) that this pattern is changing and that in a few authorities these officers also provide services for the deaf or the general classes of handicapped persons. In others, welfare officers (having taken, or preparing to take, the examination for the home teaching certificate) combine work with the blind with other duties. Home teachers provide such services as are available for the partially sighted. Our proposals and the evidence on this service are considered in paragraphs 683 to 690.

(b) *The deaf and hard-of-hearing*

652. Authorities providing services for the deaf do so, as a rule, by arrangement with voluntary organisations. They thus use the services of deaf missioners or deaf institute welfare officers who have experience, or training, in communication with and understanding of the deaf. A few authorities directly employ officers with a similar background. In one area, welfare officers able to communicate with the deaf call on the advice and skill of one of their number with considerable experience in this field. No special staff are employed in regard to the hard-of-hearing, and services for this group are mainly provided by appropriate voluntary associations. These services are discussed further in paragraphs 691 to 694.

(c) *The general classes of handicapped persons*

653. These new services, which are mainly in the experimental stage, are usually staffed by welfare officers; a number of authorities employ, in addition, occupational therapists or craft instructors. In some, visitors for the handicapped have been appointed, many of whom have a social science qualification; in one or two areas almoners include work with the handicapped in a general caseload. We have noted in (a) above that home teachers

of the blind may also play a part. The service is sometimes administered by the health department or as a separate section of the welfare department. Our views, and the evidence, are outlined in paragraphs 695 to 697.

VIEWS EXPRESSED IN EVIDENCE ON THE 'GENERAL PURPOSE SOCIAL WORKER': OUR OWN PROPOSALS

654. Early in the course of our inquiry it became evident that the term 'general purpose social worker' was being misunderstood by those submitting written evidence. Some took it to imply the creation of another grade of worker, a possibility usually viewed with apprehension. Others confused 'general purpose' with 'all purpose' and pointed out that such a person would need to be superhuman to cover the whole range of the social services. A third group took it to mean someone who performed the duties of both a social worker and a health visitor. Even among those who thought of it on the same lines as we did, that is to say as implying a broader grouping of existing functions, there were almost as many different interpretations as there were organisations. Indeed one body observed that the term appeared capable of at least four different interpretations in terms of skill, setting, function, or as a "common service corps of social handymen". When we became aware that some of the evidence was based on such misconceptions we endeavoured, so far as possible, to clarify the position amongst those giving written evidence. Later, in taking oral evidence, we gave particular attention to this point.

655. Thus the apparent simplicity of the term in fact proved deceptive. It is ambiguous, especially when applied to officers with a commonly accepted title (such as mental welfare officer), and although the concept is valuable we think continued use of the name can only perpetuate confusion. It does not, therefore, appear in our final recommendations. We do not feel able to suggest an alternative since there is considerable variation in the many different terms already in use. We hope that as an increasing number of trained social workers become generally available the title of 'qualified social worker' alone may prove sufficient and will be used only for those with one or other of the qualifications we recommend. This would be in line with existing practice for occupational therapists and health visitors. For the purpose of further discussion we take a 'general purpose' social worker to mean a trained worker who is employed to undertake a range of duties in the health and welfare services.

656. The views expressed in written and oral evidence fell into three groups. Some witnesses favoured the idea of a general purpose social worker in one form or another; others saw no place for this type of worker; and a third group, consisting mainly of medical and public health nursing interests, considered the role to be already filled by the health visitor, or that the health visitor in combination with one or more types of officer could fulfil a general purpose social work function in the health and welfare services if required. We consider the views of the first two groups below and those of the third in paragraphs 969 to 975.

657. Those who thought there was a place for general purpose social workers distinguished three categories within the total function, namely

(1) A welfare assistant to relieve trained social workers of straightforward visiting and simple welfare duties in order that their skill might be used to greater advantage.

(2) A social worker broadly corresponding to the existing area or district welfare officer but with a wider range of functions, which could include duties in the mental health and mental deficiency services and other aspects of the National Health Service Acts as well as under the National Assistance Act.

(3) A social casework adviser, consultant or supervisor to other staff in a range of services.

These three categories broadly relate to the three types of worker described in Chapter 4. We consider first the second group since it represents those undertaking the main range of social work required by health and welfare departments, next the casework adviser, and finally the welfare assistant.

'GENERAL PURPOSE' SOCIAL WORKERS CORRESPONDING BROADLY TO EXISTING AREA OR DISTRICT WELFARE OFFICERS WITH MENTAL HEALTH FUNCTIONS

658. In much of the evidence from local government officers and employing associations the area or district welfare officer was regarded as the general purpose social worker *in situ*. This and other evidence referred to the interrelation of social problems in the health and welfare services, and the resulting confusion to the client and the public if separate officers dealt with small sections of an authority's general responsibilities. It was claimed that staff could be more effectively, economically and efficiently deployed, and that personal contacts with clients and other organisations were facilitated, if only one officer worked in an area. These witnesses drew attention to the value of a co-ordinator at field level, and to the responsible position already held in this and other respects by district welfare officers. Some referred to the gap left when the relieving officer ceased to exist in 1948; The National Association of Local Government Health and Welfare Officers, for example, reminded us that

> "Whatever the failings of the Poor Law legislation may have been, it did have the virtue of co-ordinating numerous functions in the field under one officer, and Relieving Officers were frequently serving their most useful function in giving welfare advice and assistance rather than in providing monetary relief".

659. The general view to the contrary was expressed by witnesses who suggested that a general purpose social worker was not a practical possibility because of the range of knowledge required, the particular interests and abilities of individuals, and the day-to-day administrative pressures to undertake straightforward work at a superficial level at the expense of casework or other preventive work. Reference was also made to the statutory duties in the mental health and mental deficiency services which must be carried out, and to difficulties inherent in divided allegiance when an officer worked for more than one department. The Society of Mental Welfare Officers pointed out that

> "The time when the Relieving Officer tried to cope with destitution, homelessness, sudden and dangerous illness, the admission of children and of mental patients, is now fortunately past. The grave disadvantages of dealing with such a variety of demands, each with its relative degree of urgency and each requiring detailed legal knowledge and understanding, are obvious. Hence the specialisation found to have been necessary to maintain a proper standard in the work of Probation Officers, Children's Officers, Almoners, Psychiatric Social Workers, etc. We have seen the work in these fields rise to a new level of effectiveness and to revert to the old system of general purpose workers would, in our view, set the clock back by many years."

660. These two quotations from the evidence succinctly express the case for and against a general purpose social worker. Nevertheless both are based on the historic past, and comparison with the relieving officer whether favourable or otherwise is invalid because of the altered functions and structure of the services.

661. The argument regarding administrative pressures to carry out straightforward work at the expense of more thoroughgoing casework applies in many forms of social work, and not only in the context of the health and welfare services. Managing a case load is part of a social worker's day-to-day work, and managing it successfully (including the statutory obligations) should not, in our view, present an insuperable difficulty to a trained worker in a well organised and administered service—always provided that the case load itself is not unduly heavy and that adequate transport and clerical help is available. We agree that there may sometimes be dangers of divided allegiance but we take the view that this can, and should, be overcome. Some staff already successfully serve more than one department, or are shared with the hospital service; we received a good deal of evidence that such arrangements promoted co-operation and were generally welcomed.

662. The position is rather different with regard to the non-social work functions of district welfare officers—in particular, registration of births, marriages and deaths, and the safeguarding of property. It was suggested, and we agree, that the former duties are extraneous to a social work post and inappropriate for a trained social worker. We hope that authorities will consider making other arrangements in future. At the same time the safeguarding of property while the owner is in hospital may sometimes be a valuable element in the relationship between worker and client. We think this might remain among the responsibilities of welfare officers, though no doubt it could often be dealt with by welfare assistants.

663. We particularly noted the point about the interests and ability of individual workers. We agree that some people are specifically drawn to a particular type of work and might be lost to the service if, after a general training, they were unable to follow their particular interest to some extent. There should always be scope for staff interested in certain aspects of the services; it should be noted however that specialisation must, in the nature of things, restrict promotion prospects.

664. The most widespread objection related to the range of problems of varying degrees of complexity with which a 'general purpose social worker' would be faced. This is a very real difficulty in any attempt to combine functions because there is no substantial training for the majority of officers now employed. The force of the argument would be greatly diminished if a general training in social work were available nationally, and if it were appreciated that there are some situations with which only a professionally trained and experienced social worker can be expected to deal. In other words this issue raises two main considerations; the necessity for training and for a casework service. If both these were available we are satisfied that an officer corresponding to the district welfare officer or the mental welfare officer, and with a general training in social work, could fulfil a range of functions in the health and welfare services. We

recommend accordingly that (provided an adequate training is available) local authorities should consider a broader grouping of social work functions. In practice, many officers would not cover the full range, except possibly in some rural areas, because there would be a natural grouping of services according to local administrative arrangements and circumstances. But all would have shared a common training, followed later by such additional preparation as might be needed for specific work.

665. This training should enable individual officers to carry a varied case load, given experience in the local authority service, the advice and help of professionally trained and experienced social workers and the contribution and support of complementary services. In this way they would adequately meet the problems of complexity, and at the same time provide a more economical and efficient service. It is important to remember that the total service available or provided, to any individual or family, is not only the skill and knowledge of individual workers, but also the well co-ordinated resources of the whole department and of other related services, including voluntary effort.

666. Before considering how this conclusion would apply to the existing structure and making detailed recommendations for each service, we must first discuss the arguments in support of each specialisation. For completeness we include all the services.

667. There was a good deal of conflicting evidence about specialisation in the mental health service, and in the services for the blind and for the deaf. Witnesses whose work lay only in one of these fields argued strongly that the quality of the service, and the interests of those for whom it was provided, would suffer if it ceased to be completely specialised. They were in agreement, however, as to the need for training, and no one questioned the advantages of a common training for social work. Where they parted company was on the claims of individual services for additional training to be provided separately for that service alone.

The mental health service

668. The evidence showed no general agreement as to whether mental health functions were satisfactorily combined with welfare duties or required a specialist officer. Some witnesses suggested that the combination of mental health with other work was often appropriate and convenient in rural areas. On the other hand the organisations concerned with mental health considered specialisation to be not only desirable but essential if the best possible service was to be given. They pointed out that the nature of mental illness is such that personal relationships may be disturbed, and that various disorders of emotion and thinking occur. It was therefore particularly difficult, in their view, to help the mentally ill who do not always appreciate they are ill, or who may be unable to co-operate in treatment, or make excessive demands for help. Not only must social workers have the skill to meet these difficulties, but they should also be in a position to devote time and effort to the work, so as to be able to intervene at the right moment and to give support when needed. These witnesses considered any combination with other work undesirable because of the fluctuations in the demands of the mentally ill and the need to withdraw help when such persons or their families were ready to carry on alone. If mental

welfare officers had other functions they might have to re-enter the household in another capacity and thus re-open a dependent relationship. Some of these witnesses favoured a combination of function within the mental health service, but here also opinion was divided.

669. There appear nonetheless to be strong grounds for reducing specialisation within the service. In particular, the employment of officers solely to undertake the statutory procedures of removal and certification, however administratively convenient, is not in our view in the best interests of the mentally ill since it deprives them at the crisis of their illness of the help and support of a social worker who is also concerned with prevention and after-care and thus may be familiar to them over a period of time. Furthermore the problems of the mentally ill and defective can shade into each other, while the family difficulties are often similar. There may be little difference between the community care required by a mentally ill person whose psychiatric condition is static, and a stable mental defective. Flexibility also has the advantage of providing a choice of worker if a good relationship does not develop between the initial worker and the client. It allows, too, for the interests and ability of individual workers. There will always be some who do not wish to work with the mentally ill but are drawn to work with mental defectives or vice versa. There should be scope for these variations, but we see no convincing argument for a separate mental deficiency service, more especially in view of the recommendations of the Royal Commission on the Law relating to Mental Illness and Mental Deficiency for expansion in the community care of both groups in England and Wales.

670. The extent of the existing combination of mental health with welfare functions under the National Assistance Act seems to indicate that this arrangement can work well in present circumstances. It is too soon to forecast how any general expansion and development of community care will affect these areas. It appears to us, however, that the local authority mental health service will as a rule constitute one of the main groupings referred to in paragraph 664, closely linked with the hospital service, and staffed by psychiatrists and/or medical officers, psychiatric social workers and mental welfare officers. It is important, nevertheless, that this service should not operate in isolation in view of the varying degree of mental instability or incipient psychosis in some individuals and families requiring help from other health and welfare services. We envisage that all trained social workers would necessarily have some comprehension of mental disturbances, and that close liaison between the mental health and other services would always be encouraged so that consultation would be readily available if mental disorder was recognised or suspected.

671. The need for training for mental welfare officers is not in dispute ; the only question is the extent to which it might differ from that required by other social workers. In future mental welfare officers should take the general training in social work which we recommend in common with other social workers, but with an emphasis on mental health. They should have supervision on first appointment, and opportunities for refresher courses or advanced training. They would either undertake the full range of mental health duties or those most suited to their personality, training, and experience, and the administrative needs of the service. They would thus

be interchangeable within the service and would also be equipped, by virtue of their general training, for social work in other health services, or under the National Assistance Act.

672. Mental welfare officers should have psychiatric and casework consultation and advice available to them. We hope the former will be increasingly available either from a psychiatrist (or medical officer with experience in mental health) on the staff of the medical officer of health, or from a hospital psychiatrist. The shortage of psychiatric social workers at present limits the possibility of providing casework consultation for mental welfare officers; in authorities where there are none mental welfare officers should be able to consult a hospital psychiatric social worker wherever possible, as is already done in some places. These proposals are related to the existing service in paragraph 710. Psychiatric social workers are considered in paragraph 726.

673. All our witnesses in this field emphasized the necessity for a real integration of local authority and hospital services. We have been impressed by the benefit to the mentally ill, in continuity of care and in the quality of service given, when there is real team-work between the staff of both authorities. It has been suggested to us that informal joint use of staff promotes easy and effective co-operation, and we **recommend** that such arrangements should be encouraged.

Services for the care and after-care of the sick

674. We include in this grouping the tuberculosis service, the after-care of patients referred for social work by hospitals or general practitioners, and the venereal disease service. In much of the evidence about tuberculosis it was recognised that, in addition to the professionally trained social worker, there was a place for a general social worker who might combine such duties with similar work in other services for the after-care of the sick. We agree that these workers are needed. We think they should take the general training which we recommend (or part of it if they already hold a social science qualification) and be engaged either exclusively in after-care or, preferably, undertake these duties as part of a more general case load, depending on how far the service had been developed in any given authority. They should have medical consultation and also casework advice from a professionally trained and experienced social worker wherever possible. The work of almoners is discussed in paragraph 727; the proposals for these services are summarised in paragraph 713.

Social work with homeless, 'problem' or other families, including unmarried and unsupported mothers

675. A good deal of the evidence regarding social work with families, while welcoming the greater attention now paid to these problems, noted that it was still comparatively rare for a casework service to be available in health or welfare departments. Consequently the more complex situations tended to be dealt with by a variety of different types of worker. This, coupled with the fact that some workers had no social work training, often resulted in a further complication of the problem. In the experience of some witnesses this could lead to the eventual break-up of a family, and ultimately to greater

local authority expenditure by necessitating admission to temporary accommodation, or the receiving of children into care. Some witnesses, in emphasising the need for a family social worker or family caseworker, pointed out that this was *par excellence* the place for the 'general purpose social worker' in our terms of reference.

676. We agree that this particular grouping of services, in which we include those for unmarried and unsupported mothers, favours a general social worker because of the variety of problems and the many different ways in which these arise. We agree also that much time and effort can be devoted in a rather piecemeal and ineffective fashion to particular aspects of a family problem rather than to the situation as a whole, largely because the responsibilities of the workers are limited by those aspects. Obviously workers in the health and welfare services are not alone in their concern for the well-being of families, nor can they invariably do all that may be required. But their responsibilities require them to play a major part. They also enable them to detect early signs of difficulty or deterioration. Officers in the environmental and personal health services make an important contribution to this task, and their role is well established and understood. Social workers still have some way to go in showing that their contribution lies in making appropriate help available and in enabling those concerned to meet their problems. This process necessarily takes time and skill, the degree of skill depending on the complexity of the situation. In some instances a more highly qualified worker will be required but a considerable amount of work could, in our view, be undertaken by social workers with the general training which we recommend. The contribution in this field of the professionally trained social worker is discussed in paragraphs 698 to 702. We relate these suggestions to existing services in paragraphs 714 to 716.

The home help service

677. The Institute of Home Help Organisers took the view that an organiser's work could not well be combined with casework responsibilities because the main emphasis was on recruitment and organisation of staff. Other witnesses suggested that a knowledge of social work was desirable, in addition to experience or training in personnel management. Opinion was divided as to whether the organiser or the deputy organiser should undertake the social work required, or whether it should be referred to another worker who might already be working with the family as, for example, a family caseworker, child care officer or probation officer.

678. We regard this service as an essential complement to the services with which we are concerned, and to other health and related services. In our view organisers should know enough about social work and the functions of social workers to use knowledge of human relationships in their own work and to co-operate effectively with a variety of social workers. Some training is clearly desirable. We think it would be greatly to the organiser's advantage, if in addition to experience or training in administration and personnel management she also had experience or training in social work (particularly group work) in one form or another. Certain aspects of the training syllabus we propose would be appropriate for this work. If the organiser is primarily an administrator, it is desirable that her deputy or

assistant should be a trained social worker in order to advise and support the home helps with the more difficult aspects of their work. These suggestions are related to existing services in paragraph 717.

Domiciliary and residential care of the elderly

679. We received no evidence that this group of services required a special type of social worker. Some witnesses drew attention to the variety of social problems which may arise on admission to residential care or on discharge from geriatric unit. Others referred to the importance of regular friendly visiting, and of social and group activities, in combating loneliness and preserving mental health. When there were mental health problems, as for example with the mentally confused, it was said to be the usual practice to seek the help of the mental welfare officer. In one area, where welfare officers also had mental health functions, we were told that they found their mental health experience very useful in these situations. There was general agreement in the evidence on the value of voluntary services in the care of the elderly, and the importance of knitting together the statutory and voluntary resources available and ensuring that the needs of those living alone were not overlooked.

680. Welfare officers should take the general training in social work which we recommend. They would continue to be responsible for providing services under the National Assistance Act and for co-ordinating statutory and voluntary effort at local level. They might have particular responsibility for ensuring that all the services available were widely known in their own area or district, and for periodically reviewing and bringing up to date the methods by which this was achieved. They might pay special attention to voluntary visiting and meals services, and to the extent to which these meet local needs. They would encourage good neighbourliness in a variety of ways and should themselves be well known and easily accessible to people wishing to draw their attention to an elderly person in need of help. They should co-operate at all times with workers in related services, especially in the health services, and with professionally trained social workers in the after-care services when social problems arise on discharge from hospital or geriatric unit.

681. In some areas welfare officers already have responsibilities for visiting residential accommodation so as to help residents and staff with special problems. We see scope for further development on these lines particularly in the larger homes where the matron or warden may have less time to spend with the residents than they would wish. These proposals are related to existing services in paragraphs 718 to 719.

Services for the handicapped

682. These constitute a natural grouping though each of the three services has distinct aspects.

(*a*) *The blind and partially sighted*

683. The organisations concerned with the blind held the view that only a trained worker specialising in this field could assist the blind and their families to adjust to the handicap and accept the limitations it imposed, and at the same time lessen the strain and make improved functioning possible. They argued that the extent of service provided to the newly

blind, to children, adults, the elderly and the deaf blind or multiply-handicapped blind, was such that only an officer trained in the technique of teaching and rehabilitating the blind and devoting her whole time to the service could meet the need. There was no point, in the opinion of most of these witnesses, at which the blind could be said to be fully adjusted, no point at which the home teacher could safely hand over to a general worker. They agreed that a welfare officer who had qualified as a home teacher might be acceptable in some cases or in some authorities (in particular in rural areas), but they considered that blind people would resent being visited by an officer who might also visit in the neighbourhood in connection with other handicaps, especially mental illness or deficiency.

684. The core of the argument for a specialised service for the blind lies in the nature of the process which one witness described in the illuminating phrase, "teaching the blind to be blind". We are sure that this phrase describes a real function, regardless of the age of the individual, the cause of blindness or the speed of onset. The questions we have asked ourselves are: firstly whether the process of acceptance and adjustment is a special requirement for the handicap of blindness, or whether a similar process is also required with other types of handicap; and secondly whether all blind people require a full service to be available to them at all times, or necessarily need continuous skilled social work.

685. We have referred elsewhere to the common needs of people variously handicapped, and we are sure that help in accepting and overcoming a handicap is one such common need. In blindness, as with other types of handicap, the nature of the onset will have an important bearing on the social work required. Some are born blind or lose their sight in childhood or youth. Others are blinded by accident or illness in adult life. Many elderly people gradually become blind, and many blind people are elderly. The shock, and the amount of help needed in adjustment, will differ substantially in these differing circumstances. The evidence we received does not suggest that all these groups require a social worker who also has a teaching function, or that those who need, or wish, to be taught necessarily require a social worker.

686. It was, in fact, suggested by some witnesses that a distinction could be drawn between the social work and teaching functions of home teachers of the blind. Our information shows that quite a small proportion of a home teacher's time, usually less than 20 per cent, and more often only 10–15 per cent, is spent in teaching braille, moon type or handicrafts; nevertheless a major part of the training syllabus, and of the certificate examination is devoted to these subjects. Inevitably the training in other directions is correspondingly limited, particularly in the theory and practice of social work and in understanding of human relationships. In saying this we wish to give full credit to those voluntary organisations which pioneered and developed the training for home teachers. We share the concern expressed to us that candidates for the home teacher's examination are not required to take one of these training courses as a condition of admission to the examination. Thus we must agree with some witnesses that the certificate may sometimes be obtained after what is an inadequate preparation for the work.

687. We are fully convinced of the need for training (indeed more training than at present) for work with the blind. Our concern is whether it is essential, or economical, for the blind to be cared for only by workers whose training is mainly in subjects useful to a small minority of blind people. It is our considered opinion that the blind would benefit, and thus the services be still further improved, if these were staffed by officers who had a more substantial training in social work, combined with added knowledge of the needs of the blind and a wider experience in the related welfare services. We cannot believe that a mixed case load would give rise to the resentment suggested. Certainly we saw no sign of it in the course of our visit to an authority where services were provided by welfare officers who had also qualified as home teachers. There appear to us to be advantages in a visitor whose presence is not immediately associated with any one particular handicap, and we think blind people might themselves come to welcome visitors with a wider range of contacts, who may sometimes be already known to the family.

688. The needs of the blind are such that a high standard of service and of training of the workers must always be provided. Advantage should be taken of new methods or developments, and of training experience in related fields. Efforts should also be made to build up services for the partially sighted.

689. Given these essential conditions, it seems to us that there are a number of ways in which the blind welfare services could be still further improved and at the same time more closely related to other services for the handicapped. For this reason we **recommend** a variety of experiment. Some home teachers should be encouraged to take the general training which we recommend to enable them to improve their skill, and thus their service to the blind, and to widen the scope of their work. In some areas craft work might be undertaken by an occupational therapist, as we have already suggested in paragraph 519. Again, the pattern which already exists in a few authorities where welfare officers undertake work with the blind in addition to general duties might be extended, always provided they have an appropriate training. Some authorities may wish to retain, for the time being, the present pattern of staffing by home teachers, though eventually replacing them by officers with a general training in social work, combined with knowledge of the needs of the blind. Where social workers with advanced qualifications are available experiments might be made in associating them with the workers with the blind. We express no preference between these alternatives or any combination of them. Whichever is followed allows scope for particular interests, and also for workers who are themselves blind : it will be for local decision whether all should be qualified to teach braille, moon or handicrafts or whether, as it seems to us, a proportion only need be so equipped.

690. We summarise these proposals in paragraphs 720 to 721. We have considered carefully whether they would in any way reduce the efficiency of the present service for the blind and are satisfied that they would in fact lead to substantial improvement since visiting officers would in future have the advantage of a more comprehensive training than at present. In addition they would be able to provide a better service for the partially sighted. We advocate these changes because we believe they will be of benefit to both groups of handicapped persons no less than to the workers concerned.

(*b*) *The deaf and hard-of-hearing*

691. The evidence about the deaf came mainly from the voluntary organisations. It was indeed characteristic of work with the deaf that little or no evidence came from other sources. These witnesses strongly supported a specialised service, on the grounds that communication with the deaf must provide a channel of understanding as well as of interpretation, and that it would be a grave disservice to the deaf if they did not have the expert help of specialist workers. They agreed that some measure of skill in communication might possibly be acquired by local authority or National Assistance Board officers, but matters requiring skilled interpretation would always, in their view, have to be referred to a specialised worker.

692. We agree that there are unique difficulties in communicating with the deaf, but we are also disturbed to realise that the isolation which the nature of the handicap imposes is further accentuated by the complete specialisation of the service, and by the fact that so few authorities have as yet directly participated in providing it. In the present limited state of knowledge there is, in our view, a most urgent need for further research and imaginative experiment in discovering and meeting the individual needs of deaf people, and in exploring means whereby they can be brought more closely in touch with the community. We **recommend** that this should be undertaken. It is clear also that there is much to be done if local authorities are to provide an adequate service, and we should like to see more authorities helping to bring this about. This would include encouraging officers without relevant experience or training to learn to communicate with the deaf.

693. It does not appear to us practicable, however, to suggest that all local authority welfare officers could acquire real fluency in communication, but a proportion in each authority should be able, either in the course of general training or subsequently, to learn to make adequate contact with those deaf people for whose welfare they are responsible. Where greater understanding or fluency is required we hope that local authorities, while continuing to use the services of the voluntary organisations, will in addition increasingly employ their own staff for this purpose, as a few already do. We think a casework service should be provided for those deaf people who need it, even if this must be attempted through an interpreter at first. We hope authorities, either themselves or through co-operation with the voluntary organisations, will increasingly provide clubs or social activities, since these play an important part in the life of deaf people. We also hope that they will take every opportunity of educating the general public in the need to lessen the isolation of deaf people, for example by encouraging, in co-operation with the education department, the use of suitable facilities at institutes of further education. If in future more children with residual hearing are detected at an early age, and taught to lip-read and speak, this need may become less pressing, but there should always be close liaison with the education department where children and young people are concerned. We do not suggest local authorities should at any time take over responsibility for spiritual ministration, though they should see that it is available.

694. The British Association for the Hard of Hearing made it clear that they did not regard a special worker as necessary. We agree that such local authority services as may be required by individuals in this group should

normally be provided by a worker with a general training in social work. These proposals are related to the existing service in paragraph 722.

(*c*) *The general classes of handicapped persons*

695. None of our witnesses favoured a special service for the general classes of handicapped persons, but we were interested to find from the field studies an embryo specialisation developing at field level (see paragraph 549). We think it probable that the effect of a new service to meet a previously unrecognised need, combined with the present lack of an appropriate general training and the interest and enthusiasm of the staff concerned, would in time lead to a specialised service whether or not this was necessary or appropriate. We draw attention to this interesting example of the way in which specialisation tends to develop *faute de mieux*.

696. The wide range of handicap covered by this service and the variety of need confirms the evidence and supports our own view that social work should be closely related to similar work with other handicapped people, and when appropriate, with the chronic sick at home. It should not be overlooked that some older people may be unlikely to find common interests with young disabled adults and that they might prefer to use the social and other amenities available to their contemporaries. We relate these various points to the existing services in paragraph 723.

697. We regard as complementary the functions of occupational therapists and social workers. The Association of Occupational Therapists considered that its members could only play their part effectively with full knowledge of the social picture; consultation with a skilled social worker was therefore essential. The contribution of both workers may often be required, in some instances over a lengthy period. Their respective roles should always be clearly defined from the outset, though one or other will no doubt play the major part at different times according to the needs of the individual or family concerned. We see no reason why they should not visit on each other's behalf on appropriate occasions, especially in country areas where long distances have to be covered and considerable time is spent in travelling. There should be frequent consultation between them as a matter of course and also with medical and other members of the domiciliary team.

'GENERAL PURPOSE' SOCIAL CASEWORK ADVISERS, CONSULTANTS, OR SUPERVISORS IN A RANGE OF SERVICES

698. The need for psychiatric social workers was accepted by all witnesses. Many regretted that they were not more generally available. In much of the evidence the functions of almoners (medical social workers) were also recognised. Some witnesses pointed out that new methods of medical treatment and the increased turnover of hospital beds were shifting the emphasis in medical social work from the hospital to the local authority and domiciliary setting. This gave local authority almoners an opportunity, which their hospital colleagues seldom had, of co-operating with general practitioners on social problems affecting medical care in the home.

699. The social work organisations and some local authority evidence emphasised the need for family caseworkers to deal with the more difficult family problems. Some social work witnesses suggested that 'general purpose'

social caseworkers could function more effectively in a department of social work, which would service a number of other departments and provide a common casework service. We doubt whether this suggestion would be practicable in the present structure of local government though we desire to see the maximum possible degree of co-operation between social workers in different departments, and between them and medical and other colleagues.

700. We have discussed in Chapter 4 the appropriate use of psychiatric social workers, almoners and family caseworkers and recommended that they should carry a case load of more difficult cases, advise other staff on individual cases, supervise newly trained social workers and take part in in-service training. In due time we hope that workers with similar qualifications in group work and community organisation will also be available. We should like to see each of these groups of caseworkers operating throughout the health and welfare services in addition to undertaking casework in their own particular setting. In one field study it was reported that an appointment on these lines was about to be made, and we were glad to hear of this development. A more general use of trained caseworkers is not a new idea. We have given examples of psychiatric social workers advising on mental health problems in the maternity and child welfare services and with 'problem' families and families in danger of eviction, and also of almoners providing a casework service for social and family problems referred by general practitioners.

701. This 'general purpose' function is both practicable in a local authority setting and advantageous in view of the shortage of social workers with advanced qualifications. It involves a heavy responsibility, not only because individual case loads will contain a high proportion of the more difficult cases, but also in advising other staff. Because these functions require considerable skill we **recommend** that some of these posts should have senior status. The initial creation of one or more senior posts in the larger authorities would in the long run stimulate the recruitment of experienced workers. It would also encourage recruitment of newly qualified caseworkers who, in seeking first posts, usually (and rightly) prefer appointments where they can have the advice and guidance of a professionally qualified and experienced colleague.

702. It is likely, as we have suggested above, that such senior appointments will usually be appropriate in the larger authorities though the need for a casework service is not limited to these areas. We suggest that some of these authorities might consider, in view of their greater staffing resources, offering an advisory casework service to a neighbouring authority. In counties this would be to councils of smaller county boroughs or large burghs, and in large county boroughs or burghs to a council of a small county or to another neighbouring authority. Replies to the questionnaire showed that the sharing of other staff on this basis sometimes occurs already so that we think it might be developed in the way we suggest. Some such arrangement may well evolve between counties and borough councils with delegated functions under the Local Government Act, 1958, and should provide useful experience. These proposals are related to the structure of the services in paragraphs 724 to 728.

703. A number of witnesses saw a place for workers of this kind whom they described as welfare assistants or social aides. They suggested that they could relieve trained social workers of straightforward visiting and other duties and thereby enable them to make better use of their time and skill. The County Councils Association suggested that such workers might normally be on the staff of one department, but available to undertake work for other departments if required. In counties they might act as assistants to district welfare officers (though not as assistant welfare officers). They considered that this pattern, which would necessarily vary according to local circumstances, would enable the training of such officers as home teachers of the blind to be widened to cover several or all classes of handicapped persons. Two of the public health nursing organisations, while regarding the health visitor as the primary general purpose social worker, suggested in addition ancillary or social aides, pointing out that a similar type of lay helper was already employed in some health departments.

704. These suggestions relate directly to the phrase "as a basic grade" in our terms of reference. We agree that there is a need and a place in health and welfare departments for such workers, provided that they are carefully selected and appropriately trained, and **recommend** accordingly. We also agree with some witnesses that work of this kind is eminently suitable for part-time workers, including married women without younger children to care for who desire only part-time work. We have suggested (paragraphs 568 to 569) some ways in which welfare assistants might be employed. They should not undertake initial or other visiting for the purpose of assessing need, and they should work only under the supervision of a trained social worker. They might also be used to make various administrative arrangements and to carry out some 'receptionist' duties in their own departments: we relate these various suggestions to existing services in paragraphs 729 to 730.

705. We would expect that a proportion of these workers, especially the younger, will eventually wish to make a career in social work if they have the necessary educational qualifications. We hope they will be encouraged to do so. Experience as a welfare assistant would be an excellent preparation for the general training we recommend, or for a university course. We trust that local authorities will be prepared to give the necessary facilities for leave of absence and grant aid to enable selected welfare assistants to obtain a qualification in social work.

RELATION OF OUR PROPOSALS TO EXISTING SERVICES: PATTERNS OF FUTURE DEVELOPMENT

706. We must now summarise the proposals made in this and previous chapters. We have recommended three types of worker; the welfare assistant, the officer with a general training in social work, and the professionally trained and experienced social worker. We have suggested that each of these should be 'general purpose' in his own sphere, and that each requires appropriate training. It remains to indicate the duties which these workers would undertake.

707. We must emphasise first of all that these proposals depend on the implementation of our recommendations for training in Chapter 9. They cannot be implemented in isolation. Further, they require the support of occupational therapists, craft instructors, certain staff of residential homes and occupation centres, and of the home help service, no less than the contribution of other health service workers, general practitioners and workers in voluntary organisations.

708. We have no wish to lay down rigid administrative and staffing patterns. We appreciate that these must vary with the size and type of authority, the needs of the services, and the availability of the workers concerned. Obviously, the present shortages of staff will not be quickly or easily overcome, and a period of time must necessarily elapse before a complete training programme gets under way. What we outline below is simply an indication of how a new staffing structure might evolve.

OFFICERS WITH A GENERAL TRAINING IN SOCIAL WORK

709. Provided the general training we recommend is available, these officers would in future undertake the main range of social work required in health and welfare departments. This would include a large part of the work which at present makes up the caseloads of welfare officers (including district welfare officers), visitors to the handicapped, home teachers of the blind and workers with the deaf in the services under the National Assistance Act, and of mental welfare officers and other social workers in health departments, including chest clinic welfare officers. We do not anticipate that any one officer would be engaged in all these services, but that he would work in one or more depending on the local grouping of services by individual authorities. It would be for local authorities to determine the extent to which they wished to combine these functions for social work purposes.

710. The mental health service will frequently be one such grouping. Ideally it would be staffed by psychiatrists and/or medical officers, psychiatric social workers and mental welfare officers but it must be recognised that in the present shortage of psychiatric consultants and psychiatric social workers it would be unrealistic to expect that every authority could be adequately staffed in this way. We have recommended a reduction in specialisation within the service, and in particular that mental welfare officers should not be wholly employed in the statutory procedures of removal and certification. We have recommended also that these officers should take the general training in social work with an emphasis on mental health, and supervision on first employment. They would be interchangeable within the health and welfare services and should also be available to other staff for advice and help with mental health problems.

711. They should co-operate with the supervising staff of occupation centres for children and adults, especially in regard to home visiting. Normally we consider this is best undertaken by mental welfare officers but we recognise that in certain circumstances the supervisor or assistant may be the more appropriate visitor.

712. If the recommendations of the Royal Commission on the Law relating to Mental Illness and Mental Deficiency for community care hostels for the mentally disordered are implemented in England and Wales we envisage that residential staff may often be exposed to considerable strain

and stress. We think that it will be desirable for psychiatric social workers and mental welfare officers to visit staff and residents in these hostels regularly, to provide support, and to give a casework service where this is indicated. Special problems arise in the after-care of the psychopathic group, but many others discharged from mental hospitals will also need considerable understanding and support if they are to achieve a better level of social functioning.

713. In the services for the tuberculous and the after-care of patients discharged from hospital or referred by general practitioners, officers with a general training would undertake such social work as did not require the services of a professionally trained social worker, or they would work under guidance and supervision. They should have medical consultation and should be closely associated with the work of health visitors and other health workers.

714. We come now to the general category of social work with families in whichever department the need may arise. In our opinion it is clear that a general expansion and development of this type of work, of which there are already signs, is bound to take place. The fact that only a small number of health and welfare authorities are at present attempting to meet the need is accounted for by the shortage in these departments of staff suitably equipped for such work, and by a concentration on the health aspects of services provided under the National Health Service Acts without recognition of the corresponding social factors.

715. Officers with a general training in social work in either health or welfare departments would help families with a range of problems. We take the view that incomplete families—the unmarried or unsupported mother with one or more children—are also family groupings of a kind and should be treated as such.

716. In some of these family problems the help of social workers with advanced qualifications will be required. The extent or complexity of the problem will usually indicate the most suitable worker in each case, or this may be worked out at a case conference with other workers involved. Officers with a general training undertaking social work with families should co-operate with all other workers with responsibilities in this field; the health visitor, the home help organiser, and the staff of the education, children's and housing departments. This is of first importance and we return to it again in Chapter 10.

717. Officers with a general training in social work, and with administrative ability and experience in personnel management, should be eligible for appointment as home help organisers or deputies. The pattern of co-operation with other services and workers will necessarily vary in individual authorities. In many the home helps will continue to discuss their problems and difficulties with the organiser (or deputy organiser) and rely on her support and advice. She may act as the main contact with officers in other services or the home helps may consult with these officers directly where appropriate. If practical help in the home and intensive casework are both required the home help and the caseworker in the appropriate department should work together on lines similar to those described in paragraph 586.

Normally home help organisers and home helps will remain in close touch with health visitors, more particularly in the care of the sick and elderly. If the organiser is primarily an administrator, her deputy or assistant should be a trained social worker wherever possible.

718. We envisage that welfare officers will be concerned, as now, with the elderly in need of care and attention and in residential care. Generally we consider there is room for improvement in the development and integration of statutory and voluntary effort for old people. This implies early discovery of need. We discuss the role of voluntary organisations and voluntary workers in this field in Chapter 11. Officers with a general training, whether in health or welfare departments, will be in a position to see that a complete and adequate service is provided. They will work closely with home nurses, health visitors and public health inspectors, with housing authorities, general practitioners and a range of voluntary organisations and individual voluntary workers. Some of this work will continue to form part of their duties in receiving and investigating applications for residential care, but it will often be mainly required to make sure that the domiciliary services are fully utilised, and in relation to voluntary services grant aided by the local authority.

719. The increasing infirmity of old people coming into residential care casts a heavy burden on residential staff and the matrons and wardens of homes. We commend the existing training facilities for these officers and make suggestions for the future in Chapter 9. We suggest that social workers who are otherwise suitable might be considered eligible for certain residential work. Some authorities have already recognised the value of a visiting officer who will help staff and residents with difficult or special problems. We consider that there is a need for work of this kind in residential accommodation, though we should prefer that it was carried out as part of the duties of welfare officers, rather than that a special appointment should be made.

720. In the services for the blind we have recommended a variety of experiment in widening the scope of the home teacher and of relating the work more closely to the services for other handicapped persons. We suggest that some home teachers should be given the opportunity and encouraged to take the general training we recommend. Successful completion of this training might or might not lead to a change of duties, but it would confer eligibility for appointment as a welfare officer, with a wider range of function and improved promotion prospects.

721. The evidence showed that only a small proportion of the blind are being taught braille or moon. We think this should be recognised, though it would be for local decision whether all workers with the blind, or only a proportion, should be qualified to teach braille or moon. Where these workers possess aptitude in teaching crafts they should continue to provide this service, but eventually this aspect of the work might form part of an occupational therapy or craft service for the health and welfare services as a whole. We believe these developments will not only maintain, but still further improve, the present standard of the blind welfare services and in addition enable them to meet fresh demands.

722. We also make recommendations designed to relate work with the deaf to other services for the handicapped. This process will necessarily be gradual and will also take a variety of forms. We hope that all authorities will take a more direct interest in the service and will follow the practice of some welfare departments in encouraging one or more officers according to need to learn to communicate fluently and to understand the deaf. Some will wish to recruit an officer with additional training and experience (as a few have already done) to undertake the more difficult work and to advise other staff ; others will continue to rely on the advice and co-operation of officers of the voluntary organisations. In either event, the intention would be to provide a high quality of service and to make use of special knowledge and skill without establishing a separate service. We make these recommendations in the belief that they will be of direct benefit to the deaf by improving the services available, helping to lessen isolation, and adding to knowledge of their needs. Officers with a general training would also undertake such social work as was required by the hard-of-hearing.

723. We consider that social work with the general classes of handicapped persons should be closely related to similar work for the blind and deaf and, if appropriate, with the chronic sick at home. Officers with a general training should undertake such work in co-operation with professionally trained and experienced social workers and workers in related fields. We recognise the important functions of occupational therapists and craft instructors which we regard as complementary to those of social workers. Where individual welfare officers have aptitude for and ability in craft work or handicrafts of any kind, there are arguments in favour of improving or perfecting their skill so as to include these functions among other duties. We do not think however that they should necessarily be trained for such work.

SOCIAL CASEWORK ADVISERS, CONSULTANTS OR SUPERVISORS

724. We have recommended (paragraph 600) that professionally trained and experienced social workers should be responsible for the more difficult casework, to advise other staff in a range of services, supervise newly qualified or appointed social workers and assist with in-service training. In view of the need for such highly skilled workers we have recommended that some senior posts should be established for these officers (paragraph 701).

725. We have made the point that although psychiatric social workers and almoners are trained to undertake special functions this does not affect our view that they can make a valuable general contribution of the kind described. This applies equally to family caseworkers. We have given examples of ways in which they are at present being used to advise staff in related services. We hope to see further experiments on these lines.

726. In the services under review psychiatric social workers are primarily engaged in the mental health service: they should have psychiatric consultation and should themselves provide casework consultation for mental welfare officers. We suggest that the larger authorities employing psychiatric social workers might consider offering an advisory service to a neighbouring authortiy without such staff.

727. Almoners (or medical social workers) in the local health authority will continue to be concerned with the tuberculous and the after-care of patients referred for casework by hospitals, general practitioners, medical officers and other health workers. They should have medical consultation and should themselves be used generally on problems requiring casework help, and not only those with medical social implications. We have expressed the hope that family caseworkers will be attracted to the services as social work for families develops and the scope for family casework becomes more widely recognised; they also should be available for casework consultation.

728. The field work training of psychiatric social workers at present takes place almost entirely in mental hospitals and child guidance clinics, and of almoners in hospitals. We recommend that field work placements should be arranged in local authority health and welfare services for students taking a recognised training for social work (paragraph 888), and express the view that any newly qualified worker needs a carefully planned general induction to local government service on first appointment (paragraph 819). The training of other caseworkers will be affected by the future development of the generic courses in social casework (applied social studies). Similar considerations apply here too, though field work placements are already available in other local authority departments. All these categories of professionally trained social workers are in short supply. Moreover it is only after several years experience that any given worker would be qualified to fill the senior posts we have recommended.

WELFARE ASSISTANTS

729. The County Councils Association suggested that welfare assistants might normally be on the staff of one department, but available to undertake work for others, as required. In terms of their social work function, this would mean that they were available in counties to health, welfare, children's and education departments, and in county boroughs also to housing departments. We see advantages in this suggestion, though it goes far beyond our terms of reference. In health and welfare departments (whether these are separate or combined) we think they should be available to all the services which might utilise such help, that is, in welfare departments to all social work staff, and in health departments (including the mental health service) to all workers concerned with the needs of individuals and families. They are more likely to undertake work with the elderly and handicapped than, for instance, with the mentally ill or with unmarried mothers, where the situation is usually a difficult one. They could be used in the home help service, and might also help with the visiting of mental defectives where the home situation was relatively stable. They could assist generally in social and craft centres or occupation centres, according to aptitude, but there would be less direct scope for their services in work with 'problem' families, or families in danger of eviction or break-up, or with persons suffering from tuberculosis, except in carrying out straightforward work for the trained social worker in charge of the case.

730. The pattern would develop according to circumstances in each authority. Its success would depend on the extent to which planned and effective in-service training—and not just 'picking it up on the job'—was accepted as an essential element in the employment of welfare assistants. We **recommend**

their use only if they are carefully selected and employed where the type of planned and continuing in-service training which we have suggested (paragraphs 943 to 945) can be provided. It is also essential that they should be attached to and work under the supervision of qualified social workers.

CONCLUSIONS

731. We end this summary as we began, with a reference to training. We are anxious that it should be clear beyond all doubt that our recommendations with regard to social workers at all levels are made as a whole and can only properly be implemented as a whole. Without appropriate training the whole conception would be invalidated, tending in the long run to lower, rather than to raise, the standard of the social work service.

Chapter 7

RECRUITMENT: FUTURE STAFFING AND CAREER PROSPECTS

732. The evidence reaching us, including that from local authority associations, showed a widespread recognition of the shortage of social workers in the health and welfare services. Moreover recruitment, whether of trained social workers or of other new entrants to local government service, was generally considered inadequate to meet existing needs. Even the London County Council, which has never had the same difficulty in attracting social workers as other authorities, reported some difficulty in recruiting certain social workers. This they attributed to the national shortage.

733. This shortage will be accentuated in the next few years by the retirement of staff with Poor Law experience who have held appointments as welfare officers and as officers with mental health duties since 1948. When these officers retire there will be no body of men and women with comparable experience, or with a recognised training in social work, to take their place. The information given in Chapter 2 confirms the seriousness of this situation: these officers comprise over a third of all those in social work positions in the health and welfare services, and more than 40 per cent are now over the age of 50. An unusually high retirement rate is thus to be expected on grounds of age alone.

734. Apart from the need to replace officers who retire, marry or change their occupation, allowance must be made for current trends towards strengthening the domiciliary services, and also for increased demands on certain services in the coming years. In England and Wales a larger number of the mentally disordered will require community care if the recommendations of the Royal Commission on the Law relating to Mental Illness and Mental Deficiency are implemented, and a comparable expansion is likely to be required in Scotland. There is also likely to be further development of social work services to meet a variety of family situations and needs. In addition a progressively increasing proportion of elderly people in the population, many of whom suffer from the infirmities of old age or are also blind,

deaf, or otherwise handicapped, will require help. The new services for the deaf and for the general classes of handicapped persons are still at an early stage, and will increasingly demand social work staff.

735. Recruitment of local government officers of all kinds may be improved in a few years' time as a result of the increase in the number of children born immediately after the war. This is commonly referred to as the 'bulge', but takes the shape rather of a tidal bore, with a sudden jump in the number of children born in 1947 and a gradual tailing off thereafter. The crest of this wave will reach the minimum grammar school leaving age (that is to say 16) in 1963–64. Every advantage should be taken in due course of this ampler supply of potential recruits and every effort made to attract as many as possible to the health and welfare services. But although one of our witnesses considered that the 'bulge' would in itself largely solve recruitment problems, if supported by improved publicity, we do not think it can do so, so far as social workers are concerned, unless steps are taken now in line with our recommendations.

PROBLEMS OF RECRUITMENT

An unrecognised career

736. Although the views of witnesses on the cause, as well as the extent, of the shortage of social workers in the health and welfare services varied according to the opinion of the organisation or individual, the weight of evidence throughout indicated that social work in these services is an unrecognised career. It therefore rarely occurs either to professionally trained social workers, or to students taking a social work training, to seek appointments of this kind. We regard this lack of recognition as a fundamental difficulty. It was confirmed from varying angles by the field inquiries, and by our discussions with members and officers during visits to local authorities. It also applied in a slightly different form to the experienced officers, mainly men, who occupy many of the social work posts in health and welfare departments at the present time. We were concerned by the frequency with which some of the best of these officers (who themselves found great satisfaction in their work) said that they would not advise their children to follow in their footsteps because of the lack of esteem attached to the career, poor promotion prospects, low salaries in comparison with other employment, heavy responsibilities and irregular hours of work.

Lack of publicity

737. Many of our witnesses drew attention to the lack of publicity about social work in the health and welfare services, suggesting that it was not as well known, or did not have the same appeal, as child care, probation or other social work. There is clearly an urgent need to bring the value and interest of social work in this setting to the notice of existing and potential social workers, including students in social science and other university departments, and to the public generally.

738. Recent radio and television experience has shown that programmes on mental or other illness attract public interest and sympathy. Means should be taken to follow up this, and similar publicity, and to emphasise the scope and challenge of social work in the health and welfare services. We are sure that better publicity for the local government service as a whole

would also encourage recruitment to the field with which we are concerned. A good deal could be done, for instance, by individual local authorities or by their associations. We were glad to know that the latter are aware of the need to publicise the work of local government generally. Professional associations of social workers, and associations of local government officers, could also make a valuable contribution here. Government departments could play their part either directly, or by promoting better information about the services as, for instance, in the careers booklets issued by the Ministry of Labour and National Service and the Central Youth Employment Executive, as well as by other forms of publicity. It is particularly important that grammar schools should be aware of social work as a profession, and of the nature of the work in the health and welfare services as well as elsewhere.

739. We have considered the possibility of a national campaign to recruit candidates for social work, somewhat on the lines of those recently undertaken for nurses and teachers. We think some such operation desirable, but not until training facilities are available. As soon as a training programme is sufficiently well established to absorb additional recruits we **recommend** that this possibility should be explored. Any such campaign should be planned to correspond broadly with the period when the greater numbers of potential recruits resulting from the post-war population bulge are still available. We hope that local authorities and their associations, the appropriate government departments, universities and professional social work organisations would then consider the proposal sympathetically and co-operate in ensuring its success.

Attraction of other careers

740. Some witnesses attributed difficulties of recruitment to modern facilities for further education, to the attractions of an increasingly varied range of careers, and to full employment. We have no doubt that they are right, and that a number of potential recruits go into industry, commerce or other occupations, either because they do not know about social work as a career in the health and welfare services and elsewhere, or because they are attracted by the facilities for further education or training offered by some large concerns. Better publicity would help to ensure that the possibilities of a career in these services were better known, but comparable training opportunities, and the assurance of reasonable salaries and career prospects, must also be offered.

Lack of prospects

741. Much of our evidence referred to insufficient realisation of the skill required in social work, with a resultant failure to clarify the functions of trained social workers. Poor career and promotion prospects, lack of status, salary anomalies and absence of a recognised training and qualification for many essential workers were also stressed. There thus exists a vicious circle in which it is difficult to attract trained social workers for the reasons stated, yet the position cannot be substantially improved until more trained workers are available and are employed to the best advantage. These interrelated factors apply with particular force to welfare officers and mental welfare officers, whether their functions are separate or combined. The status

of the Poor Law relieving officer, which rested as much on a recognised qualification as on his statutory functions, has gone, and has not yet been replaced ; nor is an appropriate training available.

742. Our recommendations in Chapter 6 on future patterns of development should have a favourable bearing on recruitment. Experience suggests that posts which offer opportunities for a range of social casework attract more and better candidates and give better career prospects than can be expected in a narrowly specialised service. Our proposals do not preclude those with an interest in particular aspects of the work from concentrating on these later, indeed we are anxious that future development should be flexible enough to allow for these special interests.

Lack of training

743. There is no doubt that the present lack of a recognised training for welfare and mental welfare officers and other social workers gravely affects recruitment. We make recommendations to remedy this situation in the following chapters. A number of witnesses drew attention to the difficulties of obtaining grants for social work training generally, and especially for post-graduate social science or professional courses. We agree with these witnesses that the health and welfare services are at a disadvantage in this respect in comparison with the child care and probation services, where grants for training and maintenance are available to all candidates accepted for training courses. We discuss the present situation in Chapters 8 and 9, and the absolute necessity of training grants if our recommendations on training are to be implemented, and make recommendations accordingly. Here we need only say that adequate grants are essential if recruitment to the health and welfare services is to be improved. This applies to grant aid for university and professional social work courses of various kinds, and also for the general training which we propose. Candidates for training also need more precise information as to the grants available. The practice of local authorities varies considerably, and candidates may be deterred by uncertainty, or fear difficulties even where they may not exist.

RECRUITMENT OF PROFESSIONALLY TRAINED SOCIAL WORKERS

744. Psychiatric social workers and almoners are mainly employed in hospitals and child guidance clinics, partly, it appears, because they prefer this setting (in which the greater part of their training takes place) where the role of the professional social worker is more clearly defined, and where they have continued facilities for psychiatric and medical consultation. It has been represented to us that as mental hospitals and child guidance clinics are the natural centres for the clinical training of psychiatric social workers, and other hospitals provide training for almoners, students see little of local authority work during their training. However, a number of social science students have practical experience in local authority departments before they go on to these and other professional courses. We are aware of the present difficulties of providing practical training in the local authority setting at the professional stage, primarily because of the shortage of training supervisors of the required calibre. We think however that the difficulties have been too readily accepted in the past, and that they can, and should, be overcome by joint action between the universities, which provide mental health and generic casework courses, the

Institute of Almoners, and the local authorities. We think it likely that if more psychiatric social workers, almoners and family caseworkers had had field work placements as students in the health (including mental health) and welfare services they would appreciate better the opportunities of a career in these local authority services.

745. It was also suggested that there is not always the same recognition in the health and welfare services as in hospitals of the status of professionally trained social workers, with consequent restriction on their freedom to plan their own work, sign their own letters and so on. We were told that they were sometimes not fully integrated with the work of their departments, and that their functions were often ill-defined. Colleagues were therefore uncertain as to how they should be used. We think these points have substance, and that they deter professionally qualified social workers from applying for appointments in the health and welfare services. Psychiatric social workers, almoners and family caseworkers are in short supply. They are much needed in the health and welfare services, but they will not be easily attracted if their contribution is better recognised elsewhere. It is important therefore that senior administrative officers, and others, should fully understand the contribution of trained caseworkers and their methods of work. They should protect them from spending an undue proportion of time in travel and clerical work. It is equally important that these workers should on their part accept the obligation to operate within the statutory framework and local policy of the services, and should appreciate the necessity for administrative skill. We consider mutual understanding on these matters fundamental to recruitment.

746. We have discussed in Chapters 4 and 6 the ways in which professionally trained social workers can best be used, and have recommended that those who have gained sufficient experience should be responsible for the more difficult cases, for advising other staff, supervising newly qualified and appointed social workers and taking part in in-service training. We believe that the importance of these functions in relation to the needs of those using the services and the general quality of the local authority's service is such that a proportion of senior advisory and consultant posts are required, and have recommended accordingly (paragraph 701). The establishment of such posts would in our view make a real contribution towards improving the recruitment of experienced workers, and also of newly qualified staff for whom the support and guidance of an experienced colleague is an important factor in a first post.

747. We noted (paragraph 469) that the questionnaire returns showed that a number of social workers without a qualification in psychiatric social work or medical social work were referred to by the designation of a qualified worker. We therefore endorse the recommendation of the Committee on Social Workers in the Mental Health Services that the term 'psychiatric social worker' should be restricted to persons holding a university mental health certificate[1] (or who are eligible for membership of the Association of Psychiatric Social Workers). We **recommend** a similar restriction of the term 'almoner' or 'medical social worker' to persons registered with the Institute of Almoners.

[1] Cmd. 8260, paragraph 9 (iv).

748. Social work has long been a field of employment for women. A number of witnesses drew attention to the importance of attracting more men to the health (especially the mental health) and welfare services, and of providing adequate career prospects for both men and women. We have been struck by the few prospects of advancement for welfare officers and mental welfare officers, and by the small number of senior posts in these important services. We think that this shortage of senior appointments helps to discourage officers from taking further training and must certainly deter new recruits from the universities and elsewhere. Replies to the questionnaire showed that at 1st May, 1956, there were 246 chief welfare officers and deputy chief welfare officers. In addition, 73 administrative officers with some social work functions held posts which, judged on a salary basis, were senior to those of area or district welfare officers. The total number of welfare officers was 777, of whom 428 acted also as mental welfare officers. In addition there were 192 assistant welfare officers. Not all the foregoing senior posts are necessarily open to welfare officers (or mental welfare officers), indeed it has been suggested to us that field experience is not always sufficiently regarded in making appointments to senior administrative posts. Replies to the questionnaire showed that in the mental health service there were 46 senior posts for mental health or duly authorised officers, and that a total of 625 officers were employed solely in the mental health service. This suggests that only 7 per cent of the field officers had the chance of even this comparatively small advancement. In view of the responsible nature of the work and the increased demands likely to be made on this and other services, we **recommend** that, where the size of the authority and the needs to be met warrant such appointments, local authorities should consider the establishment of a proportion of senior posts in the health (especially the mental health) and welfare services.

749. A further point which has been made to us about career prospects is the uncertainty with regard to the position of chief welfare officer. Under the Poor Law the public assistance officer was a statutory appointment but there is no similar provision under the National Assistance Act. At present 65 per cent of local authorities have appointed a chief welfare officer who is responsible to the council for all, or some, of the services provided under the National Assistance Act. The remaining 35 per cent have, however, placed these services under the control of the medical officer of health or, more rarely, of the county or town clerk. We agree with those witnesses who considered that the implied limitation of career prospects could adversely affect recruitment to the welfare service.

750. We have referred (paragraph 246) to the circular[1] issued by the Ministry of Health before the National Assistance Act came into operation. In this circular the Minister advised local authorities that it was open to them either to arrange for their functions under the Act to be dealt with by a new committee, or to apply for a direction that some or all of these functions should be the responsibility of an existing committee, e.g., the health committee. Where such a direction in favour of the health committee was given,

[1] Ministry of Health Circular 70/48.

the Minister, while recognising that National Assistance Act functions would normally be discharged under the general oversight and responsibility of the medical officer of health, expressed the view that the services themselves should, so far as possible, be administered by lay (non-medical) staff and that consideration should be given to the desirability of appointing a senior officer to direct the administration of the service. In our view this suggestion is still applicable today. We therefore **recommend** that where the National Assistance Act services are separately administered they should be under the direction of a chief welfare officer trained and experienced in social work and administration. In those authorities where these functions are carried out in the department of the medical officer of health, or of the county or town clerk, responsibility to the council and general oversight of the services would rest with the chief officer, but the day-to-day administration of the services would be in the hands of the senior welfare officer whose salary and status should be similar to those of chief welfare officers or directors of welfare services having direct responsibility to councils of authorities of comparable size.

751. We are of the opinion that social work services should be administered by trained officers with both administrative and field work experience. Every opportunity should therefore be given to suitable field workers to acquire experience in administration, and thus to become eligible for administrative positions. The size and administrative structure of any given authority and the grouping of services naturally affects promotion prospects in that authority.

752. In outlining future career prospects we consider first the career of the officer who enters the service with the general training in social work. His first appointment will be as a field worker, initially under the supervision of a more experienced officer but progressively taking more responsibility for his own cases. In time he will become eligible for promotion to district, area or divisional officer in authorities where these posts exist, or elsewhere to equivalent posts combining administrative and field work duties. Assuming that he did not wish to proceed either to a professional training or to an administrative post, or was not suitable for either, this would be the limit of promotion. Some officers however given the desire, experience and aptitude would seek senior posts, and ultimately a deputy or chief officer appointment. In some authorities the top of the promotion ladder in the welfare service would be the post of chief welfare officer with responsibility both to the council and for day-to-day administration. In the health department the equivalent post would be that of senior welfare officer in charge of the social work services. Where National Assistance Act functions were discharged under the general oversight and responsibility of the medical officer of health, promotion would be to a similar post which might, or might not, also include responsibility for mental health social work. Whatever the pattern, we regard it as essential that officers who have taken a general training in social work should be eligible, provided they have the requisite aptitude and experience, to reach chief or senior officer posts. We say this for two reasons. In the first place satisfactory career prospects are essential if recruitment is to be improved, and if incentives are to be given to take appropriate training. Of equal importance is the demand now made on health and welfare authorities to provide adequate social work services. Experience and training in social work is therefore likely to become increasingly necessary for responsible administrative officers and for those directing these services.

753. Some officers with a general training will prefer to remain field workers ; for them we suggest a salary scale that will give due recognition to experience. It should be open to selected officers to apply for a professional social work training, and recognition should be given to successful completion of such training. They might be considered on a par, for purposes of status and salary, with their colleagues on the administrative side above the post of district or divisional officer. New recruits with a social science qualification should take the additional training recommended in Chapter 9 in order that their careers may follow similar patterns.

754. Professionally trained social workers should enter the health and welfare services initially as field workers. Those who wish to advance in the direct practice of social work would later qualify for posts as supervisors, advisers, or consultants. Some caseworkers also have administrative ability. It should be possible for those having the necessary aptitude to acquire experience in administration, and thus to become eligible for administrative positions. We have in mind that appointment as a divisional or area officer would be a first step in gaining such knowledge and experience. These posts frequently contain a mixture of social work and administration which would be attractive to some professionally trained social workers. They would then be eligible for further promotion under the same conditions, and with the same prospects, as the officer with the general training. Some will not wish to take either advisory posts or administrative responsibility, but will prefer to continue to exercise their skill in carrying a full case load. They should receive suitable recognition of their experience in terms of status and salary. In the larger authorities they might in due course be regarded as senior field workers.

755. In the patterns of future development outlined in Chapter 6 we described the functions of welfare assistants with an in-service training. We expect that a proportion of these officers with the necessary aptitude and qualifications will wish to apply for training, initially the general training in social work. Upon successfully completing either a general or a professional training in social work they would *ipso facto* be eligible for promotion on the lines suggested above. Those who remain as welfare assistants throughout their service should receive some financial recognition of experience in the length of the incremental scale. We do not anticipate that officers employed as welfare assistants would qualify for the administrative, professional and technical scales of the National Joint Councils in England and Wales, or in Scotland, or the equivalent scales of the London County Council.

SALARIES

756. Career prospects involve consideration of salaries. The salaries of social workers are still influenced by the fact that until comparatively recently a large number of those undertaking social work were untrained and were employed by charitable organisations with very limited resources. Then, as now, many of these workers had a sense of vocation which impelled them to the service in spite of the small salary offered. The full training of a professionally qualified social worker now takes three to four years. If our proposals are accepted, the minimum period of training for any qualified social worker will be two years. Those social workers with whom we are concerned are providing a statutory service of great intricacy, in which

normal office hours cannot always be observed, and which frequently involves much mental and emotional strain on the worker. Although we are sure that no-one will be enticed into this profession mainly owing to the financial inducements offered—nor would we desire that they should be—yet we feel strongly that the salary should be such that those who choose this way of serving their fellow men should not be at a disadvantage compared with those who choose other opportunities for service, for example in education or administration.

757. We are concerned that under existing salary scales there is often no incentive to welfare officers and mental welfare officers to take a professional social work training. The Whitley Council Professional and Technical 'A' scales for almoners and psychiatric social workers are based primarily on the hospital service. We noted (paragraph 370) that in certain respects these scales compare unfavourably with the scales determined under the schemes of the appropriate National Joint Councils for local authority services. The salaries which apply to professionally trained social workers are lower than those of some officers without such training. There is thus no financial inducement either to local authority officers to apply for a professional training or to professionally trained social workers to enter local government employment. This applies even more to almoners whose salaries under Whitley Council scales are somewhat lower than psychiatric social workers. We have emphasised throughout this Report that many more trained caseworkers are needed in the health and welfare services. We **recommend** that these anomalies should be resolved, and that salary scales appropriate to these workers should be so revised and graded as to be commensurate with the training required and the degree of skill and responsibility demanded of them.

758. Some of our witnesses pointed out that, if promotion prospects are limited by the size of a department or authority, the salary in the middle years should be commensurate with that of allied professions. It appears to us that the majority of field workers are likely to remain, and will be required, as field workers. The maximum of their salary scale is therefore a final one, and not the bridge to a new and higher scale. A longer salary scale with a higher maximum would allow for recognition of experience where promotion prospects are inevitably limited by the number of senior posts available.

SOURCES OF RECRUITMENT

759. The evidence suggests that welfare officers and mental welfare officers are at present recruited from three sources: local authority officers in health and welfare and other departments who become interested in social work, candidates with a social science qualification, and persons outside these services with an interest in social work but without suitable qualifications. We have said that lack of a recognised training is a grave deterrent to recruitment. We anticipate therefore that if our recommendations on training are implemented there should be a general improvement. This would be apparent in the existing sources of recruitment, and especially, we think, from among other local authority officers interested in social work. New sources would also be revealed. We have suggested, for example, that a proportion of welfare assistants may wish to make a career in social

work and should be encouraged to take appropriate training. We think that more young people with a social science qualification will be attracted to the services than at present if appropriate training were available for them. We expect a significant increase in interest from suitable candidates outside the services who would be eligible for the general training outlined in our proposals. It has been said that in time of full employment and manpower shortages there are no new sources of recruitment. We are sure that there is in fact an untapped source among people interested in social work or in 'welfare'. We heard of one authority which had over 70 applications for the post of district welfare officer. Naturally only a small number were at all suitable, and of these the majority withdrew on hearing the salary scale. It is however an indication that the work may have a general appeal. This would be greatly enhanced if it were known that training was available for selected candidates.

760. It was suggested to us that more married women could with advantage be employed in the health and welfare services. This was recommended by a number of employing authorities and associations, but only on condition that home commitments did not prevent them from carrying their fair share of the work. We agree that this is an important consideration. We also agree that there are many married women with limited domestic responsibilities who could make a valuable contribution in the services. With the modern tendency to earlier marriage and smaller families, an increasing number are becoming under-employed at home while still vigorous and comparatively young. Recruitment and recruitment publicity should, of course, be designed to avoid the separation of mothers and young children.

761. We refer (paragraph 947) to the need for refresher courses for women with a professional social work qualification who wish to re-enter social work after some years absence for marriage or other reason, or whose children no longer need them all the time at home. We hope also that women who enter social work for the first time in their middle years would be accepted for one of the courses we propose, or else seek appointment as welfare assistants and thus obtain in-service training. The employment of older women would accord with present national policy. In 1952 the Minister of Labour and National Service set up a National Advisory Committee to assist him in promoting the employment of older men and women. The Committee reported in 1953[1] and recommended that the test of engagement should in general be capacity and not age and that all men and women who can give effective service should be given the opportunity, without regard to age, to continue at work if they so wish. The Minister of Housing and Local Government, in association with the Minister of Labour and National Service, commended the recommendations of this Report to local authorities in a circular[2] and drew attention to the very important part that they, as large employers, could play. We welcome these trends and hope that older women will not allow themselves to be deterred by anticipated difficulties from entering or re-entering local authority employment as social workers or welfare assistants.

762. Our information shows that less than 3 per cent of all officers within our terms of reference are at present employed on part-time work, over

[1] Cmd. 8963.

[2] Circular 69/54.

half of whom are married women. The Ministry of Labour and National Service has pointed out that in teaching, which before the second world war was almost a closed occupation to married women, some 8,000 married women were employed part-time in primary and secondary schools in 1958 compared with 2,400 in 1948 ; and that the nursing profession (in which it seemed at one time very difficult to introduce part-time work) today regards married women employed part-time as a permanent contribution to its labour force. A total of 37,400 part-time nurses were employed in 1957 compared with about 5,000 in 1946 and 17,600 in 1947. We are aware of the difficulties inherent in part-time employment. Nevertheless, these figures appear to us to show that a substantial increase in employment of part-time officers, particularly married women, could be achieved in much of the field with which we are concerned, especially in work where constant availability is not an overriding consideration. It should be possible, for instance, for part-time social workers to undertake regular visiting. We anticipate that these recruits (apart from trained workers returning to employment after marriage) would be mainly employed as welfare assistants, but we see no insuperable difficulty in the part-time employment of professionally trained and experienced caseworkers as advisers, supervisors or consultants. We suggest greater use might be made of these workers in this way. This would be in accordance with the policy considerations outlined in the preceding paragraph.

763. The staffing tables show that 48 per cent of the social workers about whom we have information were women. The percentage in the various services was, however, far from uniform. Home help organisers, for example, and staff of residential accommodation were mainly women. Welfare officers and duly authorised officers were predominantly men, though we received no evidence that where these posts were held by women the duties were not satisfactorily performed. Officers in the mental deficiency service were mainly women. We have referred in paragraph 748 to the need for more men in the health and welfare services. It seems to us that recruitment may sometimes be hampered by too definite an assumption that women officers are appropriate for some kinds of work, and men for others. We suggest that local authorities might reconsider their views on this point, particularly in England and Wales in the light of the changes in the mental health service recommended by the Royal Commission on the Law relating to Mental Illness and Mental Deficiency.

764. Some witnesses suggested that mental and mental deficiency nurses should be recruited as mental welfare officers, for work in occupation centres, as home teachers of mental defectives, and as assistants to psychiatric social workers ; and also that selected mental nurses might be trained as psychiatric social workers. Others did not regard mental nurse training or experience as an appropriate background to social work in the mental health field. Some local authorities may wish to explore this matter further since a closer link with the hospital service might result. We must make it clear, however, that in our opinion all such candidates should be carefully selected, and would require training in social work. Although some suitable recruits may become available in this way, we do not expect a great number, nor would this seem desirable in view of the shortages of nursing staff in mental and mental deficiency hospitals.

765. Some witnesses suggested an increased use of voluntary workers in the statutory health and welfare services. We have much sympathy with this suggestion, which we discuss further in Chapter 11. Voluntary workers play a supplementary but essential part. They cannot, however, appropriately take responsibility for a statutory service, and we agree with the Committee on the Rehabilitation, Training and Resettlement of Disabled Persons that their recruitment cannot be expected to solve local authority manpower problems.

ESTIMATES OF STAFF REQUIRED

ECONOMY IN MANPOWER

766. Before estimating the numbers of the staff required we must first consider how existing staff can be most economically and effectively deployed. In earlier chapters we have made recommendations for economy in the use of trained social workers by the employment of welfare assistants for straightforward work, and by a broader grouping of functions (which should help to reduce the visiting area to be covered by any one field worker and thus economise in travelling time). We have also recommended that social workers with advanced qualifications should act as advisers to other staff, and carry a proportion of the most difficult cases. Further possibilities for economy are revealed in the information, discussed in paragraphs 375 to 406, on working conditions.

767. The tables in Chapter 2 show the variations between one officer and another in the proportion of working time spent in travel, which ranged from 6 per cent to 47 per cent. The average was about 20 per cent and fell not far short of the time actually spent on visits. This seems to us quite out of proportion. The saving which can be brought about by using a car will vary in different areas, but we have little doubt that where public transport is used, some officers are spending an undue proportion of time on travel. We **recommend** that local authorities who do not provide official transport should examine working conditions so as to determine whether the use of officers' own cars, or cars from an office pool, would result in their services being used more economically and to greater advantage.

768. It was suggested to us in evidence that the present shortage of social workers was accentuated by lack of clerical assistance. This absence of clerical help is confirmed by the field studies, and in Chapter 2 we noted that many officers had none. In some instances the time spent in letter writing, record keeping and other office work amounted to nearly 50 per cent of the working day. In these circumstances we are sure that better clerical help, and assistance with typing, filing and other office procedures, would bring about a real saving in the use of the time of trained social workers. It would also facilitate better record keeping which, as we have said (paragraph 606), is greatly needed. We **recommend** accordingly that adequate clerical assistance should be provided.

769. The majority of authorities already provide telephone facilities for social workers. This is not, however, an invariable rule as we have shown in Chapter 2, and without a telephone time must often be wasted. We **recommend** that wherever possible telephones should be available for social

workers. We have already drawn attention, in view of the confidential nature of much of the work, to the need for privacy for interviewing and we **recommend** that these facilities should be more generally provided.

THE SIZE OF THE PROBLEM

770. In an inquiry of this kind it is usual to try to estimate the size of the problem and we have considered how this might be done for the health and welfare services. Many of the people who need the help of social workers in these services apply, or are referred, in the first place to the local authority because of some illness or material need: for example a home help may be requested because a mother is incapacitated, an occupation centre may be required for an ineducable child or a home nurse needed to give nursing care to an elderly person. In other words, the need for social work help is frequently made apparent through the demand for other services, and this adds to the stubborn difficulties in estimating in any precise way the extent of the need for social work services.

771. In Chapter 1 we have presented the available information about the number of persons in various categories who need or may need the services with which we are concerned, including those registered as handicapped under Section 29 of the National Assistance Act. Not all local authorities, however, keep registers for all categories of handicapped persons, and even where they are kept registration is entirely voluntary. This means that registration is likely to be fairly complete only when it brings benefits that are well known and appreciated, as with blind people. Even in this group it is not uncommon to find newly registered persons who have been blind for several years. Some, including some elderly blind, do not wish to register even when they or their families are aware of the advantages. There are other categories where registration is very far from complete and remarkable differences are found between one local authority and another.

772. Estimates of the number of 'problem' families have been published for certain areas and even for the country as a whole. Dr. Blacker[1] has suggested that, according to the definition adopted, the proportion would probably be found somewhere between 0·15 per cent and 1·5 per cent of English families. In our view, however, none of the methods used to ascertain the proportion of 'problem' families are sufficiently rigorous to merit acceptance: for instance, of the definitions known to us none are objective or precise enough to make it likely that different observers could apply them consistently.

773. Similar difficulties beset the attempt to estimate the numbers in other categories with which we are concerned: even approximate totals are rarely known and difficult to ascertain. But even if this information were available, there is at present no method of telling what proportion in each category is likely to need social work help, or for how long. In some groups, such as the hard-of-hearing, the proportion seems to be very low; in others, including the mentally disordered who live in the community, it is certain to be high; in few categories is it likely to be co-terminous with the whole group. Some unmarried mothers and some evicted families, for instance, are able to make their own arrangements, or receive adequate support and help from their relations or friends.

[1] Blacker, C. P. (ed.) 1952. *Problem Families: Five Enquiries.* Eugenics Society, London.

774. Other difficulties in estimating the size of the problem include the overlap between categories which, in some cases, is likely to be quite large: 55 per cent of the registered blind in England and Wales are over 70, and 22 per cent (some of whom are included in the 55 per cent) are also deaf or have some other handicap as well as blindness. We have also borne in mind that families using both the health and welfare services may at the same time be the direct concern of the education, children or housing department. Moreover, changes in certain other services, for example increased provision of suitable housing or of homes for old people, may alter the need for social work and also affect the complexity and the duration of individual situations.

775. Our conclusion is that no reliable estimate of the size of the problem or of any portion of it is possible at present. If such estimates had been available they would have helped us to assess how large is the gap between the number who receive social work help and the number who need it. They would also have facilitated our estimate of future staffing needs which, as it is, we have been constrained to make in the absence of certain basic data. We have drawn attention to this lack of social data, a situation comparable to that which existed in the field of public health at an earlier time, in the hope that research will soon be undertaken in sample areas. We are well aware that our staffing estimates may prove to be on the low side if the provision of more adequate social work services results in uncovering hidden demand. There is however much leeway to make up in meeting known need. This is the first task and one which will undoubtedly show further needs to be met. In this connection it is necessary to bear in mind the widespread evidence of present shortages of social workers in the health and welfare services at all levels and in all types of authorities. There is no doubt that this shortage threatens to become more acute in the next few years because of retirement due to age, and because recruitment is inadequate.

CASE LOADS

776. We have found equal difficulty in considering the question of case loads, both in present circumstances and in the future patterns we have recommended. In Chapter 2 we indicated the case loads carried by some of the officers with whom we are concerned, but even in this small group the variations in function are such that precise comparisons cannot be made, particularly in regard to welfare officers and mental welfare officers. In addition staff shortages are general and many of the services are at different stages of development in different authorities. Existing establishments are, therefore, unlikely to be related either to the needs of the area or to the amount of work which can be undertaken by individual workers.

777. Nevertheless much of the evidence on this matter, our own observations, and the reports of the field studies have convinced us that many officers are currently carrying case loads which make it impossible for them to do their present work satisfactorily, and do not allow time for preventive or intensive work with those individuals or families who require such help. One field investigator noted that with the time spent on travelling and the number to be seen it was almost inevitable for workers to be swamped in 'busyness'. At present excessive case loads may result from financial

pressures, especially in smaller authorities or where large areas have to be covered. We must emphasise that in these conditions only superficial assessment is possible, practically no constructive work can be done, and wrong decisions may be made with unfortunate consequences to the person or family concerned. The heavy strain on the worker is also a serious matter. The more skilled and conscientious the officer the greater the anxiety suffered, especially when the work itself is particularly demanding. One mental welfare officer commented. "This job is all right for the right kind of person. You have to make up your mind about a case and stick to your own opinion and your decisions. If you once start thinking that you may be wrong you are finished—you begin worrying at night and cannot stand the strain." : a statement which clearly shows the need for support and guidance in this difficult work.

778. In considering case loads we have taken into account the advice given in 1951 by the Advisory Councils for the Welfare of Handicapped Persons on the maximum case loads of home teachers of the blind. In England and Wales it was suggested, in view of variations in the length and frequency of visits, distances and means of transport, that as a practical maximum home teachers should be responsible in urban areas for not more than 100 registered blind and partially sighted persons, and in rural areas for not more than 80. The Scottish Advisory Council concluded that it was impracticable, owing to the wide range of geographical and other circumstances which existed over the country, to recommend national figures. The evidence we received from the blind organisations was in agreement that the suggested figures for England and Wales were at present exceeded in nearly all areas, and this was confirmed by the information from the field studies (paragraph 389). The advice of the Advisory Councils, and the views expressed in evidence, were necessarily based on the assumption that only one type of worker (the home teacher) was employed in work with the blind and that this was her sole function. They are not therefore directly applicable to the patterns of future development which we have recommended.

779. The main consideration as we see it is that there is no information about the percentages in each category requiring help at any one time ; and the fact (as the Advisory Councils were aware) that no one figure can allow for travel in different areas and by different means of transport. Nor can it allow for the varying amount of time and skill which must be devoted to individual cases. Some inquiries, for example, may require only one or two interviews and do not develop into continuing cases. They must nevertheless be taken into account in assessing case loads. Intensive casework on the other hand may sometimes require daily visiting over a period. We have drawn attention (paragraph 444) to the small case loads which must inevitably be carried by caseworkers solely engaged in work with ' problem ' families : similar intensive visiting may sometimes also be needed with the mentally ill. Where a case load contains a mixed range of more complex problems some people will require continuing supportive help over a long period ; others may need intensive work for some time ; while others yet may need urgent and concentrated attention during a crisis though not subsequently.

780. All things considered, we have not found it possible to attempt to lay down figures for optimum or even maximum case loads, though both will become of increasing importance as the social work services expand and

trained staff become available and as more emphasis is laid on preventive work. The criteria by which case loads can be determined depends on detailed and systematic study of a kind which has yet to be undertaken in the social services, though we understand that an experimental study is in progress in the probation service. It is important that criteria should be evolved, and we **recommend** that studies should be undertaken in the health and welfare services, preferably as part of the larger inquiry already recommended (paragraph 563).

ESTIMATES OF NUMBERS

781. Our estimates of staff required and of the annual recruitment necessary to meet these requirements are based on the assumption that everything possible has been done to economise in the use of staff. We have related these estimates to the development of the services over a ten-year period. Estimates are given separately for officers with a general training in social work, professionally trained social workers, and welfare assistants. Estimates of requirements in Scotland, except where otherwise stated, are related to population.

Officers with a general training in social work

782. We envisage that the main range of social work in health and welfare departments will in future be undertaken by officers with the general training in social work. We propose therefore to discuss recruitment of these workers first. We consider the needs of each service in turn, because this seems to us the best basis on which to make estimates : but we do not intend to imply that these services will, or should, be separately staffed. Any such suggestion would, indeed, be contrary to our recommendations in Chapter 6. Our estimates are necesarily expressed in terms of the equivalent number of whole-time officers who would be required to undertake the work in each service. The sum of these separate figures gives the total number of officers with a general training which we estimate will be required.

The mental health service

783. In paragraph 233, we expressed ourselves as unable to estimate the number of mentally disordered persons in need of community care. It is clear, however, that only a small proportion of those discharged from mental hospitals are receiving such care at present. So far as we can judge the responsibilities of social workers in the mental health service in England and Wales will be greatly increased under the new arrangements for community care recommended by the Royal Commission on the Law relating to Mental Illness and Mental Deficiency. We have assumed that similar developments will take place in Scotland.

784. There were, in 1956, 625 mental welfare officers employed whole-time in England, Wales and Scotland for work with the mentally ill and mentally defective. In addition, 430 welfare officers acted also as mental welfare officers, and a number of others among the 250 chief welfare officers or deputy chief welfare officers, 200 assistant welfare officers and 210 administrative officers with some social work functions, undertook some mental health duties. The combination of functions makes it difficult to express these figures in terms of whole-time officers in the mental health service, but we estimate them as the equivalent of not far short of 1,100. We received some evidence that existing case loads were too heavy to allow of any real preventive work.

785. In 1951, the Committee on Social Workers in the Mental Health Service (the Mackintosh Committee) estimated that eventually 2,000 mental welfare officers, exclusive of psychiatric social workers, would be needed in the community care services provided by local authorities in England and Wales alone.[1] In view of the very large additional commitments which local authorities will undertake if the recommendations of the Royal Commission are implemented[2] we think it reasonable to estimate an increase in the number of mental welfare officers in England and Wales at least to the figure recommended by the Mackintosh Committee. In making this estimate we have in mind that some visiting of mental defectives could be undertaken by welfare assistants. Allowing for a comparable extension in proportion to population a further 200 should be estimated for Scotland, and we accordingly conclude that the total requirements will be the equivalent of 2,200 whole-time mental welfare officers.

Social aspects of the after-care of the sick

786. Apart from almoners, some 80 social workers are employed in health departments, mainly for the tuberculous. Some are concerned with the care of unmarried mothers and the social aspects of the after-care of the sick. These workers are not evenly distributed over the country. This adds to the difficulties of estimating, but, in itself, suggests that expansion is needed. The incidence of tuberculosis in the community, as shown by chest clinic registers, is fairly stable at about 350,000, but we are not able to estimate the proportion who need the help of a social worker. The revolutionary changes in the treatment of venereal disease have altered the significance of this disease to the patient, but there are signs that the social problems may be growing. Taking all these factors into consideration we estimate the requirements of these services at 200 social workers with a general training. This would involve an increase of 100 in England and Wales and of 20 in Scotland.

Social work with families, including unmarried mothers

787. A general expansion of social work with families is expected, much of which will be undertaken by officers with a general training employed either in health or welfare departments. Only 15 social workers are specifically engaged in this work at present but welfare officers are also concerned under the National Assistance Act. It is particularly difficult to estimate these needs but provisionally we consider the requirements of this service to be about 200, of which 15 to 20 should be employed in Scotland, mainly by the larger authorities.

The home help service

788. We said in Chapter 6 that we thought officers with a general training should be eligible for appointment as home help organisers or deputies. This implies that in course of time at least one worker with this training should be employed by each authority. We have therefore estimated the need in this service for workers with such training at 200 including 15 to 20 in large authorities in Scotland.

[1] Cmd. 8260, paragraph 69.
[2] A Mental Health Bill is now before Parliament.

Residential establishments and other services for the elderly

789. In estimating staffing requirements, we propose to consider separately the work involved in various services under the National Assistance Act. We do this in order to assess the need and not because each service either is or should be staffed by different officers. Under the present heading, therefore, we consider the duties of welfare officers in connection with residential establishments and temporary accommodation, and in other services relating to the care of the elderly. The services for the blind, the deaf and the physically handicapped are considered below.

790. A total of 1,030 officers (many of them also with duties in the mental health services and services for the handicapped), 200 assistants and 210 administrative officers with some social work functions were employed in 1956 either wholly or in part in the services considered under this heading : in all the equivalent of about 900 whole-time officers. We anticipate an expansion of work with the elderly as their numbers increase, and in the scope of work with families in temporary accommodation, but we also anticipate that a proportion of the work with the former will be undertaken by welfare assistants. All things considered, we estimate requirements at the equivalent of 1,100 whole-time officers, of whom 110 will be required in Scotland.

Services for the blind and partially sighted

791. The number of registered blind in England and Wales on 31st December, 1957, was 96,766 and in Scotland on 31st March, 1957, was 9,909. The number of blind persons is steadily increasing particularly among the elderly. About 22,000 partially sighted persons are registered in England and Wales but the registers are not complete. Registers are not kept in Scotland. About 800 home teachers of the blind (720 in England and Wales and 80 in Scotland) are employed either directly by local authorities or by a variety of agency arrangements with voluntary organisations. In future we hope that all new recruits to this service will take the general training in social work, and we do not, therefore, in our estimates distinguish home teachers employed directly by local authorities from those employed by voluntary organisations.

792. The number of registered blind and partially sighted persons given in the previous paragraph implies that each home teacher has on the average a case load of 130 blind and 30 partially sighted persons. Taking this into consideration, and allowing for a proportion of the work to be undertaken by welfare assistants, we estimate that the whole-time equivalent of 900 to 1,000 home teachers will be required, of whom 100 to 110 will be needed in Scotland, on the basis of the numbers employed there at present and figures of registered blind persons.

Services for the deaf and hard-of-hearing

793. As we have said (paragraphs 285 and 289) the present deaf registers are incomplete, and those for the hard-of-hearing bear little relation to the true figures. We have given the estimate, taken from the Central Office of Information Social Survey, that there were in England, Scotland and Wales some 1,750,000 hard-of-hearing persons of whom 30,000 were totally unable to hear speech (though they had originally learnt speech by normal means) and 70,000 were deaf to all natural speech without an aid.

A proportion of such persons may require help from a local authority social worker. We have noted in Chapter 2 that the case loads of the workers with the deaf included a number of hard-of-hearing as well as deaf persons.

794. In 1956, only 8 welfare officers for the deaf were directly employed by local authorities, and about 160 by voluntary organisations, who said however that this number was not sufficient to provide a full service. If our recommendations on future patterns of development are implemented a proportion of the work at present undertaken by these officers will become the responsibility of officers directly employed by local authorities. Religious ministration and some proportion of club work and social activities would, however, continued to be undertaken by voluntary effort. Bearing in mind all these factors we estimate that the whole-time equivalent of 150 to 200 officers will be required for employment by local authorities in services for the deaf, of whom 15 to 20 would be required in Scotland.

Services for the general classes of handicapped persons

795. Under schemes for the general classes of handicapped persons, registration is voluntary, and not all local authorities have as yet made schemes. Existing registers are therefore incomplete and many are recent. The Committee of Inquiry on the Rehabilitation, Training and Resettlement of Disabled Persons (the Piercy Committee) estimated in 1956 that the number of persons requiring the services would be about 140,000 in England and Wales on the assumption that the incidence of substantial and permanent incapacity could be taken at three per thousand of population.[1] At 31st December, 1957, there were 65,000 persons on the registers in England and Wales (an increase of about 10,000 in 1957), or approximately 1·5 per cent of the population. The registers of a number of authorities showed a proportion of more than twice this average, and in England alone the registers of three counties and five county boroughs showed a proportion of handicapped persons of more than three times the average (over 4·5 per cent). It seems reasonable to expect that the ultimate figure on these registers will be at least twice the present one and possibly three times as great ; that is to say, 140,000 to 210,000, if allowance is made for Scotland.

796. In addition to welfare officers with other duties under the National Assistance Act there were in 1956 about 100 officers whose duties were solely with the handicapped. Our information indicates that their case loads varied from about 200 to 300, and it would follow that the equivalent of about 250 whole-time officers are occupied on this work. These case loads are clearly excessive. Even allowing for a proportion of the work to be undertaken by welfare assistants, we consider that at least 600 officers will be required when registers are complete. Of these 60 will be needed in Scotland. We have suggested that some welfare officers for the handicapped should give craft instruction and we have allowed for this ; but we have not included in these estimates occupational therapists or handicraft instructors as such.

Required rate of recruitment

797. Estimates of the desirable rate of recruitment must allow for the replacement of those who leave the services as well as for the numbers needed for expansion. On both counts recruitment should be increased as soon as possible. Our estimates of the number of staff required are based on the

[1] Cmd. 9983, paragraph 125.

development of the services over a 10 year period and we have, therefore, estimated average annual recruitment at a figure which will enable this level of staff to be reached in 10 years' time. The average number of officers with a general training in social work to be recruited each year, in order to provide for replacement and expansion, is shown in Table 28. Similar figures for officers with a professional training are given in the text of the ensuing paragraphs. Recruitment will no doubt take some time to get under way, and we hope that it will run for part of this 10 year period at a much higher level than that shown.

Retirement of officers within our terms of reference

798. On the basis of the information about the ages of officers (considered in Chapter 2) we estimate that the annual rate of retirement on grounds of age alone will average about 2 per cent for all officers. For the important groups of welfare officers and mental welfare officers it will fall not far short of 2½ per cent. This greatly exceeds the rate for other services about which we have information. Retirement on other grounds is less easily estimated.

799. We have been provided with figures of retirement over a 5 year period from a small but varied sample of 189 social work posts in local authority health and welfare services. Excluding those who left to take similar posts the annual loss within these services was 6 per cent to 7 per cent of those employed, of whom 2 per cent retired on grounds of age and 4 per cent to 5 per cent for other reasons. Information provided by the Institute of Almoners showed a retirement rate, in each of the years 1956–57 and 1957–58, of 10 per cent of almoners employed in all services including hospitals. Less than 1 per cent retired on grounds of age, and over 9 per cent for other reasons, including marriage (2·5 per cent) and appointment overseas (1·6 per cent). The number resuming employment each year after temporary retirement is not known, but might reasonably be estimated at about 2 per cent of the total. Information about the retirement rates of psychiatric social workers and family caseworkers is not available.

800. We have also obtained information about other services from the Association of Children's Officers, the Home Office and the Ministry of Education. The annual retirement rate on all grounds of child care officers was 12·9 per cent in the three year period 1954–56. This is a service in which there are more women officers than men, though separate figures for retirement of men and women are not available. In the probation service the average annual rate of retirement over the five year period from 1954 to 1958, expressed as a percentage of total staff, was 3·9 per cent of which 0·8 per cent retired on grounds of age and 3·1 per cent for other causes. The figures for 1958 distinguish between the sexes. For men the retirement rate was 1·8 per cent (0·3 per cent on grounds of age) and for women 5·5 per cent (0·7 per cent on grounds of age). Information on teachers in pensionable employment under the Teachers' Superannuation Act showed once more a loss of women officers proportionately greater than that of men. In the financial year 1956–57 the retirement rate of all men in this category was 2·1 per cent (0·5 per cent on grounds of age) and of all women 7·8 per cent (0·8 per cent on grounds of age). A significant number of officers, both men and women, who had retired in earlier years re-entered the services in 1956–57 so that the net wastage was only 1·1 per cent for men and 4·4 per cent for women.

801. These figures show very wide variations between different services. The only constant factors are that the rate of retirement of women is greater than that of men and that retirement on grounds of age, where it can be distinguished, is less than retirement for other reasons. In course of time we anticipate that our recommendations for improved career prospects and the provision of training, will lead to a reduction in the rate of retirement. Even making allowance for this, however, we would not feel justified (at least over the next 10 years) in estimating the numbers of newly recruited officers with a general training in social work who would be needed to replace those retiring on grounds other than age at less than 3 per cent to 4 per cent, or to replace those retiring on all grounds at less than 5 per cent to 6 per cent, of the staff at any one time. We are conscious that this estimate may prove to be conservative. At present, almost all officers with a professional training in social work are women, and we have therefore estimated their retirement rate at 8 per cent. In all our estimates, including those in Table 28, we have also taken into account the fact that, as the number of officers increases, the numbers of those who retire from the services will increase also.

Table 28 : Officers with a general training in social work : present staffing and estimated staffing requirements

Services	Estimate of numbers of staff expressed in terms of whole-time equivalents[1]			Estimated average annual recruitment in terms of whole-time equivalents[1]		
	Present staff	Total require-ments	Total increase	To meet retire-ments	To provide for increases in staff	Total
Mental health service	1,100	2,200	1,100	100	110	210
Care and after-care services	80	200	120	8	12	20
Social work with families	15	200	185	6	19	25
Home help service...	—	200	200	6	20	26
Services for the elderly	900	1,100	200	60	20	80
Services for the blind and partially sighted	800	900—1,000	100—200	50	10—20	60—70
Services for the deaf and hard-of-hearing	10	150—200	140—190	6	14—19	20—25
Services for the general classes of handicapped persons	250	600	350	24	35	59
	3,155	5,550—5,700	2,395—2,545	260	240—255	500—515

[1] The presentation of these figures in terms of whole-time equivalents for each service separately does not imply that these services are, or will be, separately staffed.

Officers with a professional training in social work

802. In paragraphs 803 to 810 we consider separately the requirements over a 10 year period of psychiatric social workers, almoners and family case

workers. In view of earlier recommendations that such officers should undertake casework in their own and other settings we think there should be some flexibility as between groups, provided that the overall estimate is retained. We have made separate estimates on this understanding. In all we estimate that 800 officers with a professional training in social work will be required, and we recommend that this figure should be reached within 10 years. We estimate the necessary annual recruitment to meet anticipated needs and to allow for retirement at 105.

(a) *Psychiatric social workers*

803. The need for more psychiatric social workers generally, and not only in local authority health and welfare services, has been frequently emphasised in recent years, notably by the committee on Social Workers in the Mental Health Services (The Mackintosh Committee[1]) in 1951 and the Committee on Maladjusted Children (The Underwood Committee[2]) in 1955. The Mackintosh Committee estimated the demand for psychiatric social workers for all services at 1,500, including 800 for hospitals and clinics, 500 for child guidance and 200 for the after-care services of local health authorities. This last figure is further considered below. The Underwood Committee estimated that 420 psychiatric social workers would be needed for child guidance alone.

804. When the Mackintosh Committee reported in 1951 there were 331 qualified psychiatric social workers in posts in the United Kingdom, of whom only 8 were employed by local health authorities. By 1956–57 the total number of psychiatric social workers had risen to 505, an annual increase of 29, allowing for wastage and retirement. Of these, 26 were employed whole-time, and 5 part-time, by local health authorities in community care; in addition a small number were employed jointly by local health and hospital authorities. A further 165 were employed in child guidance clinics and 211 in hospitals. Figures in the Mackintosh Committee's Report show that over the four years 1946–47 to 1949–50 an average of 49 psychiatric social workers qualified each year, and figures subsequently provided for us show the same average number for the seven years 1950–51 to 1956–57. We have no doubt that a great increase is urgently needed in the number of psychiatric social workers trained each year, so that they may meet a variety of demands, of which those within our terms of reference are only part. We must accept however that even if numbers increase a general shortage of these social workers will persist for some years to come.

805. Any attempt to estimate the number of psychiatric social workers required in the services with which we are concerned is particularly difficult in view of the wide divergence between the sheer needs of the situation and a realistic appraisal of what is at present possible. On the needs of the situation the Mackintosh Committee said

> "It has been suggested in some quarters that for the care and after-care of persons suffering from mental illness there should be one or two psychiatric social workers per hundred thousand of the population. This figure does not mean very much, and we know no method of arriving at a sound general estimate. The principal functions of psychiatric social workers would be supervisory and consultant, for the bulk of the work outside the hospital and clinic services would be undertaken, as at present, by mental welfare workers. We feel,

[1] Cmd. 8260, paragraphs 43–53.
[2] Ministry of Education, 1955, paragraph 380.

however, that Blacker's estimate of 100 is too low, in view of the increasing functions of local health authorities in mental welfare and of the need for supervision of in-service training. We therefore suggest an estimate of 200, by the time that our schemes of training are in full operation ".[1]

806. We are in the same difficulty as the Mackintosh Committee in making a general estimate of need, or of relating requirements directly with population. The Society of Medical Officers of Health (Scottish Branch) expressed the opinion that every local health authority should have at least one psychiatric social worker, and that larger authorities should have more, though not a large number. Allowing one psychiatric social worker to every authority with a population of under 100,000, and two on the average to all larger authorities, this would involve a total of about 325 psychiatric social workers in health departments of whom 230 would be employed in England, 70 in Scotland and 25 in Wales. We do not think this unrealistic in terms of the need for such staff, but the particular difficulties of recruitment in smaller local authorities shown by the staffing figures in Chapter 2 make it unlikely that the desired number could be directly employed by local authorities in the foreseeable future, or distributed as suggested. Nonetheless it is extremely important, in view of the expected expansion in the local authority mental health service, that psychiatric social workers should be more generally available. We hope that all local authorities will do everything in their power, by co-operation with one another, and with hospital authorities, to make them available.

807. All things considered, we think that the Mackintosh Committee's estimate is the most useful for immediate needs, but that an increase of not less than 50 per cent should be allowed for the increase in local authority responsibility for community care. We think, therefore, that over a period of 10 years the aim should be that the equivalent of not less than 300 whole-time psychiatric social workers should be available to local authorities, whether by direct employment, or by arrangement with hospitals or neighbouring authorities. Taking into account both population, and the general need for such workers, we provisionally estimate the needs of England and Wales at 260 and those of Scotland at 40. In view of the small numbers currently employed, it is plain how urgent is the need for improved recruitment. During the next 10 years requirements will be determined mainly by the need for expansion, and losses by retirement or otherwise will initially be comparatively small. We estimate requirements at an average of 40 recruits annually until the minimum figure of 300 is attained. After that about 25 recruits will be needed each year to maintain numbers, and we would hope that actual expansion could then begin in relation to the needs at that time.

(b) *Almoners*

808. Almoners, like psychiatric social workers, are in short supply both generally and in local authority health departments. The Committees on Medical Auxiliaries (The Cope Committees), which reported in 1951, estimated that about 2,500 to 3,000 almoners would be needed to provide a full hospital service in England and Wales, and about 500 in Scotland. They

[1] Cmd. 8260, p. 19, paragraph 49. The reference in this paragraph is to C. P. Blacker, *Neurosis and the Mental Health Services*, 1946, p. 94, Humphrey Milford, Oxford University Press. The Survey was made in 1943 and based on information relating to 1938, 1940 and 1942.

did not feel able to define the limits of the almoners' functions outside hospitals or estimate the numbers needed, though they thought the requirements of local authorities almost certain to increase.[1] In 1956, of a total of 1,165 almoners, 1,039 were employed in hospitals, 56 in local authorities and 14 jointly between local authorities and hospitals. The uneven geographical distribution of almoners employed by local authorities is a serious matter. In London and South-East England 44 qualified almoners, including those shared with hospitals, (more than 60 per cent of the total) are employed to serve a population of 13½ million. A similar population in Northern England is served by seven almoners only, there are two in Scotland for a population of 4·9 million, and one in Wales for a population of 2·5 million.

809. We are satisfied that there is room for a considerable increase in the number of qualified almoners in the local authority services, and that they should be more uniformly distributed. We estimate that a total of 300 almoners will be needed, of whom 30 should be employed in Scotland. In order to reach this figure in 10 years, annual recruitment should be 40.

(c) *Family caseworkers*

810. The use of professionally trained caseworkers, other than almoners or psychiatric social workers, in the health and welfare services is a recent development: at present barely a dozen such officers are employed. We have recommended that they should deal with family problems, including 'problem' families, and we hope that they will be increasingly attracted to the services as the scope and interest of the work become more generally known. In estimating future requirements at 200, of whom 20 should be employed in Scotland, and recruitment needs at 25 per annum, we are conscious that we may prove to have been unduly conservative.

Welfare assistants

811. As soon as in-service training is available the recruitment of welfare assistants should be undertaken. It seems to us that at least 200 welfare assistants should be recruited annually for a period of 5 years. Experience should then make it possible to estimate further requirements. We do not at present feel able to make any estimate of the numbers which may ultimately be needed.

[1] Cmd. 8188, Part II, paragraphs 114, 121.

PART III

Chapter 8

TRAINING: EXISTING FACILITIES AND THE CASE FOR TRAINING

812. In this chapter we propose to outline the university provision for social work education, that is to say, the general social science courses which lay the foundation for a social work training, though they are not primarily designed as vocational courses for social workers, and the professional social work courses which are intended to follow them. We shall also outline the provision outside the universities for training of certain social workers within our terms of reference, and give examples of refresher courses and other in-service training. In Chapter 9 we make detailed proposals for training.

813. We received a considerable amount of written and oral evidence about training. This came from local government associations and authorities, local authority employees, the university social science departments, various social work organisations, and allied professions—medicine, public health nursing and occupational therapy ; and also related to practices in several other countries. It can thus be said that a varied range of representative organisations put their views before us and afforded us the benefit of their opinions in discussion. Naturally there were considerable differences in the angle of approach and therefore in the views expressed. But what strikes us most in considering this weight of evidence is the almost universal agreement that some kind of systematic and planned training is necessary for social workers in the local authority health and welfare services. There were differences in point of view about the importance of training, its length, the form it would take, and the persons who should benefit from it. But we ourselves were surprised by the wide measure of agreement amongst these very diverse bodies that the demands made by present-day social services could not be met without some form or forms of training.

814. We were greatly impressed by the urgency with which the case for training was put to us by those officers in the services—chiefly mental welfare and welfare officers—who have themselves had no opportunity for training. They, and others, pointed out to us the vacuum created in 1948 when the old Poor Law Examinations Boards ceased to exist. We are well satisfied that they are right to recognise that the best available knowledge and skill are needed to understand and deal with the many difficult problems which come their way. We also agree with the view of these officers that a national qualification would help to secure recognition that their function is an important one, demanding both training and a high sense of responsibility. It was impressive to us to discover how often those with the best potentialities and experience were the ones most eager for the enlightenment and support which they felt good training would give them. We are glad to be able to record this because, although we cannot speak too highly of the hard work and single-minded devotion to duty, or of the kindliness to the handicapped,

the mentally afflicted and the old which we found to be widespread among those holding posts with a social work function in the services in question, yet we agree with their view that the service they were able to render was more limited than it need have been because of their lack of training. We also agree with those who drew attention to the status given by a nationally recognised qualification, and that this is likely to further the more effective discharge of social work functions in the social services. We agree, too, that status based on qualifications and experience is an important element in good service as well as in recruitment.

EXISTING PROVISION FOR TRAINING

815. The general pattern of training for all types of social work in this country takes the diverse forms which we outline in the succeeding paragraphs.

(a) **University social science or social study degree, diploma or certificate courses (which usually include practical work)**

816. These courses range from one-year post-graduate certificate courses to three-year courses leading to an honours degree. We understand that the tendency is towards substituting honours degree courses in sociology or social studies for diploma or certificate courses, though some of the latter are likely to be retained for older candidates. It is much to be hoped that an increasing number of the staffs of health and welfare departments will in future have taken these degree courses, which give students a good grounding in the social sciences and the elements of social research. The subjects included in practically all courses are social economics, social administration and legislation, psychology, and social history, while sociology has been introduced into most of them in recent years. A number also include social philosophy or political theory, social statistics and social research method. There is also a wide range of optional subjects in various universities. The range and depth of the subject matter differs considerably from one course to another, so that no general assumptions can be made about the ground that will have been covered. Some degree courses do not include any practical work : it is, however, usual in many of them for students to be required to spend several months in practical work. This may be in various branches of the local authority services, in family casework agencies and other voluntary organisations, in probation services, in hospitals, approved schools, Borstal, children's homes, clubs and settlements, factories, and so forth. Opinions appear to differ as to the exact purpose of this practical work ; some hold that its aim is to illustrate and make realistic the study of social administration by giving students some direct experience of the actual operation of certain social services, and also to afford them contact with people having a variety of problems. Others go further and say that it should also include the first stage of a training in casework or group work. We understood in evidence from the Joint University Council for Social and Public Administration that these various social science courses are regarded by the University Social Science Departments as " academically complete ". But, as the Joint University Council went on to point out, they

> "... do not adequately equip the student to take a responsible social work post. We now generally regard them, from the vocational point of view, as a preparation for the professional training which should follow. To be recognised as fully

trained, the present day social worker should both have successfully completed a general course in social studies and also have taken a social work training, usually lasting approximately a year, leading to a professional qualification."

817. In addition to these full-time courses, London University provides an external diploma in social studies, as a basic academic qualification for a professional career in social work, for candidates who are unable, for financial or other reasons, to take full-time courses at a university. The theoretical part of the course may be completed either by attendance at part-time lecture courses available at various technical colleges, or else by private study. The requirement for practical work is normally six months full-time work under supervision, in a placement arranged by the university.

818. Several universities also provide extra-mural or extension courses (without practical work) which sometimes lead to a diploma or certificate but are not recognised as the equivalent of a full-time social science course, nor as a training in social work.

819. Efforts have been made by many local authorities in recent years to attract candidates with social science qualifications into their services. Some have assumed that these were trained social workers, whereas in fact they have proved to require quite substantial in-service training after appointment. It would be our view that any newly qualified worker needs induction into local authority work in general, and the work of the individual local authority in particular, as well as support in consolidating newly acquired skill. At the same time, it appears that there is considerable confusion about the nature and purpose of social science courses. In the present shortage of social workers, many students go straight into such employment after completing one of these courses. This is hardly satisfactory if the student has, in fact, only had a preparation for a professional training.

820. We sympathise with the university view that basic studies should not have a vocational slant. We think that a social science degree, diploma or certificate provides an excellent background for employment in various forms of local authority service. But these studies do not by themselves qualify students as trained social workers. Thus we agree with the Joint University Council and other witnesses that academic studies with a little practical experience do not constitute training for social work. This training essentially requires that students should have systematic experience in relating theory to practice, both in classroom study and supervised fieldwork, in order to learn social work method and to give them a good grounding in some aspects of administration. Thus, only those who have taken one or other of the professional courses referred to in paragraphs 822 to 827 can at present be regarded as qualified social workers.

821. A dilemma has thus arisen in that courses which the universities look upon as non-vocational are regarded by many of those who take them, and by employing bodies, as giving a vocational qualification. It would be comparatively simple to deal with this situation if all those with a social science qualification who intend to become social workers could be required to go on to take a professional qualification. But in the present shortage of man-power, this would be well-nigh impossible. The alternative of integrated three year or four year courses, including professional training, is, as we understand it, not consistent with university policy. We make

recommendations in Chapter 9 about grant aid to make it easier for students to take social science and professional courses. We do not, however, think that this in itself will affect the entry into social work of persons who hold only a social science qualification and who do not return later to take a professional course. It is not for us to suggest remedies for a situation about which there is general concern, both within and outside the universities. It would seem to be for the universities themselves to work out possible solutions with employing bodies and other interested parties.

(b) One-year professional full-time courses (usually following a social science or other related qualification)

822. Several of these professional courses (child care, generic casework, medical social work and psychiatric social work) are provided by social science departments in co-operation with hospitals, child guidance clinics, probation services, family casework and other voluntary and statutory social agencies. The training is confined to casework at present (that is to say there is almost no provision for professional training in group work or community work). All these courses include study of human growth and development and individual variation, with the intention of increasing the student's understanding of the dynamics of family life, of human motivation, of normal and deviant behaviour, particularly under stress, and ability to recognise the signs of mental illness. Some also include study of the social influences on behaviour. A good deal is taught about the operation of particular social services and legislation, though less about administration. In all the courses an important part is played by the study of the principles and practice of casework, using for this purpose analysis of detailed case records, as well as general teaching. The trend is towards concurrent theory and practice, that is, field work under supervision on two to three days of the week in addition to the time spent on theoretical studies. This field work also becomes full-time for part of the course, so that in fact students spend more time in practice than on theory. The supervisors are specially qualified in order to be able to teach in relation to the students' actual cases, and to help them to acquire the necessary skill.

823. In the field covered by our inquiry, these courses at present include the training for psychiatric social work given in the mental health courses at Edinburgh, Liverpool and Manchester Universities and the London School of Economics; the almoner training provided by the Institute of Almoners and the medical social work course at Edinburgh University; the generic casework (applied social studies) courses at Birmingham and Southampton Universities and the London School of Economics. Those persons who have completed a university post-graduate degree or diploma course in social work in one of the Dominions or in the United States of America would be regarded as holding an equivalent qualification.

824. Mention should also be made here of the advanced course in casework run by the Tavistock Clinic, although it does not lead to a qualifying award. The course is normally taken by persons who already hold a professional qualification and who wish to carry their studies further.

825. In the generic courses the emphasis is upon the similarities, the 'generic' in all casework, that is to say social work with individuals, no matter in

what particular setting it is practised. The Joint University Council pointed out in its evidence that

> "as regards the training of the full-time professional social worker there is a growing appreciation of a common body of knowledge which all can and should share."

Students who successfully complete the generic courses are recognised by the appropriate bodies as being qualified in casework as such, and (according to the nature of their field work and special classes) as almoners, child care officers, probation officers and family caseworkers. In addition to taking employment in these specific services several have been appointed as workers with 'problem' families and one as a welfare officer in a local authority welfare service.

826. Table 29 shows the numbers of students who completed social science courses in 1957 in the 24 social science departments affiliated to the Joint University Council (including Belfast and Dublin), and the numbers who completed the various professional casework courses in the same year. In addition, in that year, 18 students completed the London University External Diploma in Social Studies.

Table 29: Number of students completing university social science courses and professional training courses in 1957

Course	Students completing course
University social science courses	
Two year diploma or certificate courses	259
One year post-graduate diploma or certificate courses	93
Degree courses which include practical work	111[1]
Degree courses which do not include practical work	50[1]
University and other professional training courses	
Mental health certificate courses	46
Generic casework courses	30[2]
Medical social work course	10[2]
Child care certificate courses	58
Institute of Almoners' course	82
Personnel management courses	31

[1] Students completing degree courses in university social science departments do not necessarily take up professional social work.

[2] The 10 students taking the Edinburgh University medical social work courses and 9 of those taking generic casework courses also qualified for membership of the Institute of Almoners.

827. It will be seen from the foregoing summary of the present position that the bulk of the professional training facilities are in the universities, or else require a university qualification for admission to them. In the field with which we are concerned, no systematic training is available (other than for home teachers of the blind) for those who are, for one reason or another, unable to take a university course.

(c) *Ad hoc* specialised courses provided outside the universities

828. Intermediate between the university and *ad hoc* specialist courses is the training for moral welfare workers at Josephine Butler Memorial House in Liverpool; as noted in paragraph 193 this may include the social science certificate course at Liverpool University.

829. The most comprehensive of the *ad hoc* training courses taken by officers within our terms of reference are those for home teachers of the blind. Training covers an academic year, and is designed to prepare students for the examination of the College of Teachers of the Blind. Courses are held by the North Regional Association for the Blind, the Southern Regional Association for the Blind, the Scottish National Federation for the Welfare of the Blind, and the Glasgow and West of Scotland Mission to the Outdoor Blind. The syllabus provides for instruction in the subjects of the examination syllabus (braille, moon, professional knowledge and home occupations) and also includes practical work of 3–5 weeks with an experienced home teacher, and 2–8 weeks in a family casework agency. In order to give a background of general social welfare, courses in social study are arranged where possible in co-operation with the universities (for example, in the north courses are held at Holly Royde Residential College of the University of Manchester). Refresher courses are also provided. In addition a course of three months duration, usually organised by the North Regional Association for the Blind, is held for training home teachers of the blind already employed by local authorities or their agents who have had not less than six months practical experience in the work.

830. The qualification of home teachers of the blind is the Home Teaching Certificate of the College of Teachers of the Blind. Candidates for the examination on which the certificate is awarded must not be less than 21 years of age and must have had a good general education. The examinations may be taken by candidates who have not taken the training courses, as well as by those who have. After two failures candidates may take the examination again only if sponsored by the employing local authority and with the permission of the Ministry of Health. During the three year period 1953–55, the certificate was awarded to 192 candidates, of whom 111 had taken regional training courses. Twenty-three candidates from these courses, and 59 others, were unsuccessful.

831. The qualification for welfare officers for the deaf is either the Diploma or the Certificate of the Deaf Welfare Examination Board, the distinction being that the examination for the diploma includes a section on theology and spiritual ministration, which is not required for the certificate.

832. The examinations of the Board are open to those who, except in special circumstances approved by the Board, are at least 23 years of age and have served under a qualified missioner or superintendent in an approved society for not less than 3 years. The examination for the diploma covers general knowledge, social science, special and practical skill and theology and spiritual ministration, while that for the certificate covers the first three of these only. Candidates are required to satisfy the examiners in each section, either by taking the examination set by the Board, or by submitting certificates which allow of exemption. The period of in-service training is at least three years. Candidates for training, who must normally be over 20 and under 30 years of age, are required to undergo a probationary period of six months before being finally accepted. In the five year period 1952-56, the diploma was awarded to 21 candidates out of 51 who sat the examination. The only candidate who sat for the certificate was successful. The standard required in the theoretical studies for home teachers of the blind or welfare officers to the deaf is not comparable with that for university courses.

833. The Institute of Social Welfare, founded in 1953, has among its objects that of providing, promoting and encouraging suitable training for welfare officers and others engaged in the social services of local authorities and approved national bodies. Centres have been established in England and Wales, Scotland and Northern Ireland where members meet for educational purposes to hear lectures, discuss and debate matters concerning social welfare and analogous matters, to make visits of observation, and generally to assimilate knowledge concerning their profession. In addition, the Institute has endeavoured to work out examinations in consultation with the Local Government Examinations Board and other bodies concerned.

834. When we were appointed, the Institute suspended their efforts to establish training, apart from a pilot scheme of in-service training for matrons and assistant matrons of old people's homes run in co-operation with the National Old People's Welfare Council. We have been greatly impressed by the efforts made by the Institute, with limited resources, to further the training of local government officers in the social welfare field. We do not think, however, that a sufficient training can be provided except by a co-ordinated and adequately financed scheme on the lines which we propose in Chapter 9. Nonetheless we hope that voluntary and professional organisations will continue (and indeed increase) their efforts to provide all kinds of refresher courses, conferences, and other forms of educational activity.

835. In 1950, the National Old People's Welfare Council pioneered a training course for matrons of old people's homes, consisting of integrated practical and theoretical training under the direction of an experienced tutor. Between 1950 and May 1956 these courses (which now last 14 weeks) were attended by 140 students of whom 87 were subsequently employed by local authorities.

836. The Institute of Home Help Organisers (founded as the Association of Home Help Organisers in 1947) gave us details of a proposed three months course, including both theory and practice, for future home help organisers. We understand, however, that it has not yet been found possible to put this proposal into effect, and that the Institute are preparing as an alternative to provide correspondence courses, lasting six months, for existing and future organisers.

(d) **In-service training : refresher and other courses**

837. All the foregoing courses are intended to provide some kind of qualifying award. In addition, refresher and other short courses are provided by professional and other associations such as the Institute of Almoners, the Association of Psychiatric Social Workers, the Association of Social Workers, the Institute of Social Welfare and the National Association for Mental Health. These courses are intended either for social workers in a particular branch, for example almoners, or for those from a more varied range of services. The courses provided for the past few years in Leeds under the auspices of the National Association for Mental Health (to which reference was made in paragraph 227) are a particularly interesting example of what is in fact a form of systematic in-service training. These courses, which are refresher courses for existing officers of some years standing, are in three parts, the first and last of which are residential and consist principally of lectures, demonstrations and discussions illustrated by case material. The intermediate

part comprises a number of seminars held once a week at four centres and spread over a period of 20 weeks, excluding breaks for Christmas and Easter, at which each student presents a case, including an outline of work done, as the basis for a discussion within the group led by a psychiatric social worker.

838. So far as residential work with old people is concerned, the National Old People's Welfare Council have also organised residential refresher courses for wardens, matrons and assistant matrons of old people's homes. Between 1949 and 1956 these courses were attended by 651 wardens and matrons, of whom 431 were from local authority homes. In Scotland similar courses organised by the Scottish Old People's Welfare Committee in 1955, 1956 and 1958 were attended by 181 wardens and matrons, of whom 82 were from local authorities.

839. In our questionnaire we asked whether any provision was made for planned in-service training in health and welfare departments or for release to take refresher or other courses. Forty-eight authorities (25 per cent) replied that they provided in-service training. In the majority of these the arrangements described consisted of training 'on the job', that is working under the guidance of senior or experienced staff, rather than of planned courses. It was clear from the replies that the majority of authorities were willing for new or junior staff to take appropriate training if difficulties of finance, time and/or suitable facilities could be overcome. The urgent need of mental welfare officers in this respect was mentioned by a number of authorities, some of which had made special arrangements for these officers to attend mental hospital out-patient clinics and ward rounds, and to sit in at lectures given to the hospital staff.

840. Two authorities gave particulars of planned in-service training, covering a set period of time, with a syllabus and including both theory and practical work. Glamorgan County Council provides in-service training for home teachers of the blind and for home visitors for the handicapped lasting in each case about a year. Somerset County Council originally designed their scheme of in-service training of mental welfare officers for a period of up to 2 years, dependent on the previous experience and qualifications of the candidate. But in view of the recommendations of the Royal Commission on the Law relating to Mental Illness and Mental Deficiency the authority felt that experience alone without some academic qualification was unlikely to meet future requirements. Endeavours have accordingly been made to supplement in-service training by part-time attendance at a social science course. In-service training is divided into four stages of graded responsibility: a probationary period; a period of instruction in general administration, legal principles of the statutory work of local health authorities, and office techniques, combined with field work as assistant to the district officer; a period of secondment to mental and mental deficiency hospitals; and finally a pre-appointment period both in the office and the field.

841. So far as attendance at refresher courses and other courses of one kind or another is concerned, 89 per cent of authorities replied that they were willing in principle to give leave of absence for this purpose, but in many instances this applied to one or other department and not both, or the return showed that no opportunities had occurred, or that the staff was too limited

to allow the necessary time off. A number of authorities permitted attendance at study groups organised within the services and many encouraged attendance at extra-mural classes or schools.

GRANT AID FOR STUDENTS TAKING TRAINING

(a) **University social science or social study courses**

842. Financial provision in England and Wales for students taking these courses is normally made either by a local education authority grant or by a state scholarship awarded by the Ministry of Education. It has been stated in evidence that local education authority grants are far from uniform, and also that some local authorities are unwilling to grant aid students who already have a degree in another subject. The Ministry of Education will extend awards to state scholars with a good degree and a recommendation from the university from which they have graduated. However, very few appear to take social science degrees.

843. In Scotland grants are normally made by the local education authority, the amounts being prescribed under the Education (Scotland) Act, 1946, and regulations made thereunder.

844. The Home Office provides grants through the Probation Advisory and Training Board for probation students for whom the Board recommends a social science course to be followed by a university generic casework course or the Home Office probation course. Thus a number of such candidates receive grant aid for a three-year training. The Home Office, through the Central Training Council in Child Care, may grant aid a child care student to take a one-year social science course as a prelude to a university child care or generic course, that is, for two years in all.

(b) **Professional courses**

845. The Home Secretary has powers under Section 45 of the Children Act, 1948, to defray or contribute towards the cost of maintenance of persons undergoing approved training in child care whether as child care officers or house parents. Similar powers under Section 77 of the Criminal Justice Act, 1948, enable him to give financial support to persons being trained as probation officers or for work in approved probation hostels or homes or in remand homes or approved schools. In either case the necessary funds are provided from a pool to which the Exchequer and local authorities make equal contributions. There are no similar powers in the National Health Service Act, 1946, or the National Health (Scotland) Act, 1947, or the National Assistance Act, 1948. The Minister of Health and the Secretary of State for Scotland, however, have authority by agreement with the Treasury to make training grants (within a limited sum annually) to candidates for training as psychiatric social workers or almoners who have not been able to obtain grants from local education authorities.

846. Since 1953–54 the Minister of Health, and since 1955 the Secretary of State for Scotland, have awarded a number of exchequer bursaries annually for students training as almoners (for whom training under the auspices of the Institute of Almoners has existed since 1905 and within the university since 1954). Since 1949–50 similar awards have been made for those who intend to become psychiatric social workers (for whom training in certain university social science departments has existed since 1929). Candidates in

England and Wales are required to sign an undertaking to work in the National Health Service for a specified period. Few unfortunately have been attracted into the local authority services.

847. We were informed that candidates who wished to become general or family caseworkers, or who had not yet decided which profession they wished to follow, experienced considerable difficulty in obtaining grant aid from local education authorities. The Joint University Council argued very strongly against the present earmarked grants and in favour of uncommitted grants at the professional training stage.

848. We received a good deal of evidence to suggest that local education authorities are reluctant to give further assistance to graduates whom they have already aided for three or four years, and either turn down the application or give an unrealistically small grant. Lack of grant aid for training in family casework was particularly mentioned as a deterrent to the recruitment of family caseworkers.

(c) *Ad hoc* **courses provided outside the universities**

849. There is normally no source of grant aid for students wishing to train as home teachers of the blind or welfare officers to the deaf, apart from local education authorities. Blind or partially sighted students, however, may receive financial help under the vocational training scheme of the Ministry of Labour and National Service during training as home teachers of the blind. Organisations concerned with the training and examination of home teachers of the blind told us that local authority grants for students had always been limited, and were becoming increasingly hard to secure. A number of selected candidates had to withdraw each year because they had failed to get such grants. Those concerned with the training of the deaf referred to financial difficulties both in providing training and in maintaining students during training.

(d) **In-service training**

850. Where the officer undergoing training is employed by a local authority, that authority may, under the scheme of conditions of service of the National Joint Council for Local Authorities' Administrative, Professional, Technical and Clerical Services, pay 75 per cent of tuition fees, registration and exemption fees, and of expenses incurred in travelling and in taking essential practical training: in addition the full examination fees may be met by the authority at the first attempt. These arrangements came into effect in 1952 but so far as we are aware have rarely been applied to candidates for social work training. Leave of absence may be given on full pay, or on some proportion of full pay or without pay. An officer who applies for training may thus be put to some financial loss, though it is open to local education authorities in these circumstances to make a contribution towards tuition fees and maintenance costs. The Home Office provides full salary as well as tuition fees for serving child care officers given leave of absence by their employing authority (whether a local authority or a voluntary organisation) to take a university one year child care or generic course. Similar facilities exist for serving probation officers. Pension rights are maintained.

851. The general picture is thus one of considerable complexity with varying powers in different fields. The candidates may all be persons who have been selected to train professionally for social work, yet two groups, child care and probation, are automatically assured of grant aid, whereas varying degrees of uncertainty attach to the rest. Apart from the inadequacy of grants for training for general or family casework, to which some witnesses referred, it was suggested that this uncertainty was in itself a considerable deterrent to candidates, who preferred to take up training for which financial support was more assured. Uncertainty or delay may be increased if the grant of bursaries from central funds is dependent on the failure of individual local education authorities to use their powers to make grants for training.

THE CASE FOR TRAINING ON A NATIONAL SCALE

852. Only a minority of officers with a social work function in the health and welfare services have any qualification other than experience, and only a very small minority have a social work qualification. Table 42 shows that of 1,828 welfare officers, mental welfare officers and administrative officers with some social work functions employed in 1956, over 60 per cent had no qualification apart from experience and less than 8 per cent held a social science qualification. Of the group of 3,353 social workers considered in Table 44 (which comprises all the main categories of social worker in local authority health and welfare departments apart from psychiatric social workers and almoners) 93 per cent had no qualification in social science or in professional social work. If psychiatric social workers and almoners are taken into account this proportion was over 89 per cent. Moreover, almost no provision is made for systematic in-service training by local authorities, and release to take refresher and other short courses is rare. This situation may be partly related to the extreme shortage of qualified social workers, to the fact that almoners and psychiatric social workers are accustomed to work in a hospital or clinical setting, and to the shortage of refresher courses. Nonetheless the comparison in Table 30 with other public services employing social workers shows that the local authority health and welfare services have not succeeded in recruiting nearly so large a proportion as these other services of officers with social science qualifications or a professional training in social work.

853. The Regional Associations for the Blind, the Deaf Welfare Examination Board, the National Association for Mental Health and the Institute of Social Welfare have made substantial efforts within their limited resources to provide some kind of training for various officers in the health and welfare services. These unaided resources have, however, understandably enough proved inadequate to the task. Thus the vacuum created by the abolition of the Poor Law Examinations Boards has not been filled, so far as the health and welfare services are concerned, by any uniform training at a standard commensurate with present day requirements.

854. The lack of provision for training is perhaps most serious in regard to mental welfare officers, as they themselves were the first to point out. One of them gave the following vivid account in his logbook of what may happen in the present lack of training.

> " I am appalled at the total absence of any system of training or selection in the appointment of duly authorised officers. I have experienced and observed new appointments to this important post recruited from general clerical grades

having no previous experience of any type of social work. Some of those appointed were immature and quite incapable of appreciating the impact of mental illness on an individual, his family or the community around him. Their only training was to receive incoming telephone calls from doctors, hospitals, etc. referring cases to be dealt with under the Lunacy Acts. After one or two weeks of this duty they were allotted to an observation ward. Some time later these officers will be expected to go into the field and to resolve serious mental illness problems objectively to the advantage of the patient, his family and the community."

Table 30: Qualifications of selected groups of officers (England and Wales, and Scotland)

Employing authority or department	Designation of officers	Numbers of officers holding			
		Professional qualification in social work	Social science qualification	Some other qualification[1]	No qualification
Local authority health and/or welfare department (employed wholetime or part-time but not shared with other bodies, e.g. hospitals).	Welfare officers (including chief welfare officers) and mental welfare officers.	4	139	611	1,090
	Psychiatric social workers and other social workers employed in community care.	31	8	—	—
	Almoners registered with the Institute of Almoners, and other social workers without an almoner's training.	56	28	15	32
Other local authority departments and public services.	Psychiatric social workers (and social workers employed in psychiatric departments and clinics).				
	(*a*) In child guidance clinics.	165	Not available		
	(*b*) In hospitals	211			
	Almoners in hospital.	1,039			
	Child care officers.	263	428	346	
	Probation officers.	848	104	297	

[1] For the qualifications held by welfare officers and mental welfare officers see paragraphs 325, 332 and 333 and Table 42.

855. The Mackintosh Committee, reporting in 1951, recommended a system of in-service training under the supervision of experienced psychiatric social workers or mental welfare officers. They also recommended that local authority officers entering the mental health services for the first time should have a preliminary period of training under an experienced worker to provide a general background, and to determine whether they were personally suited to the work. This, it was suggested, should then be followed by in-service training. The Association of Psychiatric Social Workers subsequently sponsored a trainee scheme under which trainees are appointed for not more than two years to approved posts in mental hospitals and local health authorities where they work under the supervision and guidance of trained psychiatric social workers. Suitable trainees are then accepted for one of the university mental health courses. By October, 1956, 33 trainees had qualified as psychiatric social workers in this way. We have noted (paragraphs 226 and 227) that the proposals for the training of mental welfare officers made by the Mackintosh Committee, and subsequently by interested bodies, did not come to fruition because of the Minister's view that the training of social workers in the local authority health and welfare services should be considered as a whole.

856. The position is substantially the same as regards the training of welfare officers. In paragraph 302, we drew attention to the report of the Committee of the Advisory Council for the Welfare of Handicapped Persons which considered the training and qualifications appropriate to welfare officers in the services for the handicapped in England and Wales under the National Assistance Act, 1948. The Committee recommended two types of training, one for existing officers and new entrants with some previous general social work training or experience; the other for new recruits to the service without either social work training or experience. For the reasons given, and in view of the known intention of the Minister of Health to initiate our inquiry, no further action was taken.

857. There thus lies behind us a long history of failure to take the vigorous action necessary to provide trained social workers for the health and welfare services. Neither local authorities nor voluntary organisations ought to be expected to provide training facilities of the necessary magnitude, whilst it is also evident that the university social science departments cannot meet the need. The position has become increasingly acute during the ten years since 1948 for a number of reasons to which we have referred in this Report. These include the rapid expansion of local authority services for the general classes of handicapped persons, and the Piercy Committee's conclusions as to the need for further development; the Report of the Royal Commission on the Law relating to Mental Illness and Mental Deficiency and comparable reviews in Scotland; expansion in social work with families including 'problem' and homeless families; the increasing proportion of elderly people in the population; the wider public who now use these services. We have also noted the high proportion of officers in welfare departments who are reaching retiring age. New recruits to the services, by and large, have no recognised qualifications. Thus, as officers with Poor Law qualifications reach retiring age, welfare departments will become the only local authority departments staffed with officers without a recognised qualification. The same is also to a large degree true of health departments, so far as officers within our terms of reference are concerned.

858. We have no doubt that the demands made on these services require well trained and experienced staff. As has been said, almost all our witnesses recognised the necessity for training for social workers (though they saw it in different terms) in the local authority health and welfare services. Some saw it mainly in terms of greater familiarity with the social services and their operations ; others, who also recognised the importance of this, laid greater emphasis on training as a means of giving workers a better understanding of human needs and relationships, and thus of social problems, together with greater skill in helping people in distress to meet their varied difficulties.

859. We were frequently impressed on our visits by the kindliness and native wisdom of many of the visiting officers. However, as we have noted (paragraph 588), a fairly substantial proportion of cases require a higher level of insight and skill than the untrained worker can be expected to have. We also noticed the tendency of many untrained workers to give unrealistic reassurance and to try to cheer people up rather than allow them to talk about the fears, anxieties and uncertainties which they frequently—and often realistically—felt. Often these would have been lessened by being expressed to an understanding listener, and this might have indicated appropriate action, for example where a mother was uncertain about the best way to handle a handicapped adolescent showing behaviour problems. We noticed that many of our witnesses concentrated their evidence on the type of handicap from which the persons in question suffered, rather than on the very different effects which this may have in causing personal stress and family tension, taking into account the person himself and his family and social circumstances. We also noted that those giving evidence seldom referred to the effects on the family and its life of the handicapped member's presence, though in fact this is usually a major element to be reckoned with in effective social work with handicapped people.

860. Some other witnesses saw at the core of the social worker's function the ability to detect signs of excessive strain which might not always be obvious (because masked by cheerfulness or stoicism or antagonism), and to help the handicapped person and his family to reach a better adjustment, often through the understanding relationship which the qualified social worker is not only able to offer but also to use with conscious direction. As one group of witnesses expressed it

> " The real need of the client may be very different from his initial request for help . . . The caseworker must therefore be able to take stock of the background situation in considering any request; to be skilled in exploring the tangle of mixed motives and conflicting feelings with which clients so often confront him. He must have the patience to help the client to reach his own decision rather than to urge him to adopt this or that solution ".

861. Our own impressions were confirmed by the findings of our investigators, and have been discussed in more detail in Chapters 4 and 5 as illustrating the kind of social work required.

THE TYPES OF TRAINING REQUIRED

862. As we have said (paragraph 562) we have come to the conclusion that the content of the case loads of social workers throughout the health and welfare services can broadly be divided into the following categories:

(*a*) People with straightforward or obvious needs.

(*b*) People with more complex problems, who require systematic help from trained social workers.

(*c*) People with problems of special difficulty requiring skilled help by professionally trained and experienced social workers.

863. This raises a difficult issue, which many of our witnesses and we also have looked at from every angle ; that is to say whether one or more than one type of training is required in the service. There is the further question whether a general training or a series of specialised trainings is what is needed. While we sympathise with the aspirations of those who would like to see every social worker in the service with a university social science qualification we do not think this is realistic, nor do we think that this alone would produce sufficiently well equipped workers without a further professional training containing a good deal of practical work under supervision. Having regard also to the extreme shortage of professionally trained social workers and to the needs of other social services we do not think it would be possible, nor indeed necessary, to aim at staffing the health and welfare services in this way.

864. In rejecting this proposal, we find little appeal in the opposite suggestion that the requirements of the service could be met by a short course of a few months duration followed by a little in-service training. We do not think present day demands, still less those of the future, could be met in this way.

865. A third alternative suggested in various evidence is that a training should be provided for 'welfare' workers, consisting partly of theoretical and partly of practical work. This suggestion was most fully developed by the Joint University Council, drawing as much on the extensive experience of staffs of social science departments, in the training of many different kinds of welfare workers through extra-mural or special courses, as on experience of teaching university students. The Joint University Council recommended

> "That so far as possible workers from many different fields (not only those employed in health and welfare departments) should be brought together for the academic part of their training for welfare work . . . The lecture courses and tutorials for welfare workers should cover:
>
> (i) The development of social policy and its expression in social services.
>
> (ii) Principles and practice of social administration.
>
> (iii) Human development and behaviour.
>
> (iv) Human relations in the administration of the social services.
>
> Much greater emphasis should be laid on the quality and nature of the teaching given to the students than on the examination itself. Particular value should be placed on the student's contribution to group discussions which might form part of the total assessment of the student's suitability".

This suggestion is in some ways attractive, though we do not accept the rigid distinction made by the Joint University Council between 'welfare' workers and caseworkers.

CONCLUSIONS

866. We are convinced that the very rapid advances made in the social and behavioural sciences make it possible to provide a standard of service far above that which was previously possible. Moreover, the public is becoming

much more aware of the relation between stress and physical illness or nervous breakdown, and of the importance of helping people with problems of human relations, as well as providing material benefits. This, as we have said, calls for a more skilled service in the psycho-social field, and thus for qualified social work staff in the local authority health and welfare services. The need for well trained and experienced social work staff is recognised in the majority of services other than those under the National Health Service and National Assistance Acts.

867. In our view, the essential case for training is that a body of knowledge now exists which individual workers cannot acquire by experience alone, and that social work practice now rests upon a systematic method and principles of work for which individual workers need training. In the following chapter we shall make detailed proposals about the forms of training which seem to us to be required, and the ways in which these could be provided during the coming years when the need will become even more urgent than it is at present.

Chapter 9

TRAINING: OUR PROPOSALS

868. In this chapter we make proposals for training, and discuss in detail the ways in which we think these might be implemented. We are anxious that our recommendations should be capable of flexible application, both to existing staff and to new recruits. This has meant going into a certain amount of complex detail, because we would not feel justified in making general recommendations without at the same time describing how we think they could be implemented.

869. We have discussed in Chapter 8 the various suggestions put to us about training courses. Taking into consideration the situation as a whole, we think that these do not constitute alternative choices but that each represents a realistic appraisal of the requirements of the total service at one level or another. We therefore accept these various suggestions as being appropriate if woven into a total pattern of training. We have, inevitably, found ourselves faced by the dilemma of whether to pitch the standard of training so high that it would in fact be unattainable ; or so low that it could not meet the needs of the service ; or so much in the middle of the road that it would be at the same time too complex and too simple. In these circumstances, we have taken the analysis of the case loads themselves as our guide and concluded that more than one type of training is required. We accordingly **recommend** two types of social work training : (a) university social science courses related to professional courses on the lines of those which at present exist for psychiatric social workers, almoners, and generic caseworkers ; (b) a general training outside the universities (which does not at present exist) for social workers who would deal with all but the most complex problems. In addition we recommend systematic in-service training for welfare assistants who would undertake some of the more straightforward work under the supervision of trained social workers. Various short courses and refresher courses are also required for all workers.

870. These types of training would result in the following pattern :

(i) To train social workers :

(*a*) A university degree, diploma or certificate in social science, followed by the best professional training available ; in other words the highest social work qualification which the country provides at any given time. These courses at present involve three to four years of full-time study and practice (paragraphs 816 to 827).

(*b*) A general training of related theory and practice, including social science and methods subjects, to be given in colleges of further education or other educational establishments, with the co-operation of the universities. It is essential, in our view, that such training should lead to a national qualification of sufficient standing to be recognised by the Local Government Examinations Board and by the appropriate National Joint Councils as qualifying for certain appointments and for promotion, as well as for an appropriate grading on the administrative, professional and technical salary scales. The necessary ground could not, we think, be covered in less than two years full-time or three to four years of combined part-time and full-time study and practice, of which the final year should be full-time. We discuss these courses in more detail in paragraphs 889 to 904.

(ii) To train welfare assistants :

Planned in-service training designed to give understanding of common human needs and stresses : to develop interviewing skill at an elementary level : to demonstrate the work of the departments and other relevant social services, and the importance of team-work ; and to train such workers to detect early signs of stress or other problems beyond their capacity to handle unaided. We discuss this in-service training further in paragraphs 943 to 945.

871. We see in-service training for welfare assistants as being a most valuable avenue for entry to the services to test aptitude for the work. Some who came in at this level might, for one reason or another, be satisfied to remain there ; others would leave to train, and would gain very much more from their training because of this experience in a local authority. Many older married women might also be well satisfied with the varied work available at this level. We would regard those who have taken the general training, or who are welfare assistants, as eligible for further training on proof of capacity. Thus officers who had been recruited to the local authority service at the age of 16 or 17 years, and who subsequently desired to become social workers, might, when they were old enough, begin to undertake some of the simpler work with in-service training and supervision, that is they would be trained as welfare assistants. If they showed real aptitude for the work and had the necessary educational qualifications they should then be given leave, by a combination of day-release and full-time leave, to take the general training. Alternatively, some who were appropriately qualified might go straight on to take a social science or related professional qualification.

872. The need for refresher courses apart from, and complementary to, the two categories of basic training is more fully considered in paragraphs 947 to 948.

873. A national qualification calls for provision of training on a national scale. The Joint University Council for Social and Public Administration suggested in evidence that what they termed a central welfare training council should be set up for this purpose. The functions of this council, as suggested, would be to sponsor and promote training, which would be provided locally, to approve training courses, approve or conduct examinations, and lay down, in co-operation with local authorities and other agencies, the general principles of practical work training. It might also be responsible for the provision of special courses for supervisors of in-service training, as well as for co-ordinating certain specialised aspects of training at present provided by the organisations for the blind and deaf and the National Association for Mental Health.

874. The central welfare training council, in the form in which it was put to us by the Joint University Council, was to be responsible for the training of ' welfare ' officers for other public services. We ourselves cannot comment on the merits of those aspects of the proposal which lie outside our terms of reference: so far as the health and welfare services are concerned, the proposal appealed to us so much that we sought the views of other witnesses and in this way consulted some 21 organisations in oral evidence. Of these, 16 were in favour and 4 were uncertain or non-committal. Only one was against the suggestion of a central council, while agreeing that training was necessary. We were particularly encouraged that most of the existing training bodies approved the idea and promised their support if such a body came into being. In general terms this support was based on the belief that a training council of this kind would in time establish a common national standard of training and thereby give to social workers a nationally recognised status, which in turn would stimulate recruitment and foster real co-operation between workers in the field. It was also recognised that none of the existing organisations had the resources to provide or sponsor training on the scale required.

875. We accordingly **recommend** that a National Council on these general lines should be set up as soon as possible as an independent representative body with its own premises and staff, charged with the responsibilities outlined below. This recommendation is one which should be given the highest priority in view of the extreme urgency of providing well-planned training for new recruits and for present staff, especially for officers in the mental health service. We suggest that the council should be called the National Council for Social Work Training. We **recommend** that it should be financed from public funds : this is not only essential if the Council is to function effectively, but is also in line with current practice in relation to the training of other workers for the public services.

876. The National Council would be responsible for recognising courses to train students for the national qualification which we propose below, and for securing the provision of a sufficient number of such courses. We do not contemplate that it would normally run any of these courses, though occasionally it may prove desirable for it to do so. One of its chief responsibilities would be to decide how a national standard could be achieved, to work out criteria for the qualifying award to be known as the National Certificate in

Social Work, and to make the award to students who successfully complete recognised courses. The experience of other training bodies, such as the National Council for Technological Awards, the Central Training Council in Child Care and the Probation Advisory and Training Board would, no doubt, be valuable in this respect, though we would not suggest that any of these should necessarily be taken as a precise pattern for the powers or procedure of the proposed Council. Each operates in a rather different way, all of which would provide useful guides. The National Council for Technological Awards approves full time ' sandwich ' courses for the Diploma in Technology on application from Colleges of Technology and Polytechnics, provided it is satisfied about teaching facilities and the conduct of examinations. The Central Training Council in Child Care sponsors one year professional courses in university social science departments for child care students who already have certain qualifications, as well as courses of similar length in colleges of further education for those who intend to become house parents in children's homes, or to work as house staff in homes and schools for handicapped children. The Probation Advisory and Training Board runs a professional training course, and both it and the Central Training Council in Child Care select candidates and undertake publicity. Both of these Councils also sponsor a wide range of refresher courses. The experience of the Public Health Inspectors Education Board may also in due course be relevant, since its scheme of paid pupillage for public health inspectors, inaugurated in 1958, depends to a great extent on the provision of whole-time practical training by selected local authorities.

877. Although the National Council should not itself normally provide the general training courses for the qualifying award which we propose, we think there would be advantages in its assisting with a variety of short courses and refresher courses, in addition to those which may be run by other organisations. These would not of course be intended as training for a qualification. They are, however, a necessary part of any comprehensive training service, and unless some are actually planned by the National Council we could not see sufficient being made available over the whole country, particularly for the considerable number of officers without training who will remain in the services for some years to come.

878. We think the National Council would have a most useful function in conducting publicity campaigns on a national scale, and in various other ways stimulating recruitment to the services. It might assist in the selection of students. It could also play an important part in collecting and making available the teaching materials, case studies, films and other visual aids and various teaching devices which would be needed. We would also like to see it conducting some direct in-service training projects on behalf of local authorities, particularly in the early days when experience is being gained in training generally.

Organisation and finance

879. We have recommended (paragraph 875) that the National Council should be financed from public funds. As we understand it, it will not be possible to do this under existing statutory powers. We therefore **recommend** that the necessary legislation should be introduced at the earliest possible opportunity. We make other recommendations about legislation in paragraphs 936 and 957.

880. The National Council will inevitably be a large body, since it will need to draw for its membership on all the teaching, training, employing and other interests concerned. In order that it should not become unwieldy and slow in operation, it might, we think, need to work through a small executive committee. A professional board may also be necessary to take responsibility for the detailed organisation of that part of the work of the Council which is more strictly educational, such as the approval of syllabuses and centres for training, and the approval and conduct of assessments for the qualifying award to be made by the Council. The National Council would be responsible for the general lines of policy to be followed, but it might be desirable that the professional board should have some degree of independence. Such a board, appointed by the Council, might include persons with expert knowledge and experience who were not necessarily themselves members of the Council.

881. We have said (paragraph 875) that we think the National Council should be an independent body with its own premises and staff. A small secretariat of social work educationalists and others will be needed to take responsibility for the implementation of policy, and for day-to-day planning. They would act in an advisory capacity as regards the syllabus and content of training courses; conduct negotiations about courses; ensure that candidates put forward for the award of the National Certificate in Social Work had adequately fulfilled the requirements; collect, edit and make available case records, visual aids, bibliographies, and other teaching materials. They might sometimes help with actual teaching, and from time to time assist in planning refresher or other courses. This would require the necessary funds for these purposes, as well as for the national publicity which would be an important function of the Council in stimulating recruitment.

The relation between the National Council for Social Work Training and the universities

882. The Joint University Council's suggestion for a central welfare training council did not include any aspect of the university courses, though so far as the training of 'welfare' workers was concerned they noted that their suggestions "would place a responsibility on the universities and local education authorities to provide, in co-operation, suitable courses . . .". We welcome the willingness of the universities to play a part in this training. Many witnesses have been eager to have the support of, and to profit from the knowledge and experience of, the universities in the joint planning and operation of training schemes. We hope that universities would be prepared both to contribute from their experience to the work of the National Council and also to consult with it about the training and employment of students taking the appropriate university courses. We think that courses outside the university as well as university or related professional courses are both equally necessary. We hope, however, that no barriers not inherent in the courses themselves or in the educational standard of the students will separate one type from the other. We refer to this in paragraphs 871 and 904: it is enough to say here that we are confident the university social science departments would be prepared to take an active part, by co-operation and mutual consultation, in the work of the National Council for Social Work Training.

883. In view of the extreme shortage of social workers we hope that the universities will do everything in their power to increase the number of students taking social science courses followed by professional training, and that the number of these latter courses will be steadily increased.

The relation between the National Council for Social Work Training and other educational establishments

884. We would envisage that the National Council would take the initiative in requesting suitable colleges of further education or other educational establishments to run general training courses leading to the National Certificate in Social Work. At the same time it would also be necessary to hold discussions with local authorities, mental hospitals and other agencies in the neighbourhood about the facilities for supervised practical work which they might be prepared to provide. These two aspects are interconnected with each other in that suitable facilities for both theoretical and practical training must be available (or capable of being provided) in a particular locality before plans can proceed. At the next stage joint discussions would be required between the National Council, the training establishments and the local authorities about the number of students to be accepted, staffing, the curriculum, the full-time and part-time study which would be necessary and the accommodation, library and other teaching resources which would be needed. We consider the selection of students further in paragraph 890. In the early stages when qualified staff is scarce, it might be necessary for the National Council to second one or more of its own staff to a new course to teach the social work methods course and to assist and support the local authority supervisors of practical work. This would make for more economic use of scarce teaching resources and save wasted effort. We refer (paragraphs 907 to 910) to the problem of providing adequate field teaching (supervision). We do not like the term 'supervision' to describe what is really a tutorial teaching function in field practice, but since it is now commonly accepted we are constrained to use it.

The National Council and possible regional arrangements

885. We see some analogy between our proposals and the pattern of teacher training colleges related regionally to university institutes of education : nevertheless we propose a National Council. This is because some training for social work is at present the responsibility of various *ad hoc* national bodies outside the universities, while professional (as distinguished from social science) courses are at present available only in 6 out of the 24 social science departments affiliated to the Joint University Council. The expansion which we propose therefore inevitably requires national planning and support, but we hope that from the beginning close connection would be established between particular universities, other educational establishments, and employing authorities. We think this might be facilitated by some form of local or regional arrangements in co-operation with the National Council, and with appropriate local representation, including universities and other training bodies.

886. We cannot emphasise too strongly that we regard field teaching, based upon actual responsibility for a small case load, as of equal importance with theoretical study in all forms of training for social work. This field teaching or supervision is essentially a tutorial relationship with a group of students, with all the merits of this relationship from the learning point of view. As we see it, theoretical studies and field teaching are two parts which should fit together to make a whole. It follows, then, that local authorities have a vital contribution to make; indeed the training for social workers which we recommend cannot come into existence nor develop fruitfully without the active co-operation of these authorities, especially those in proximity to the chosen training establishments. We do not wish to minimise the demand which this field teaching would make on certain local authorities in terms of staff time, accommodation for students and other necessary ancillary services. The time of well qualified social workers would have to be made available for student supervision; in some instances special appointments would need to be made. When we discussed this with the local authority associations, as well as with representatives of senior officials, we were greatly heartened to find they took the view that the obligation to provide teaching facilities for a variety of professional students was well recognised. To provide similar facilities for social workers going into the health and welfare services would thus simply be an extension of the accepted practice. If officers already in the employment of other authorities were sent as students, or if students who were new recruits took appointments after training with other authorities, this would also be accepted, since authorities with greater resources regarded themselves as having an obligation to contribute to the whole service. This liberal attitude encourages us to think that local authorities would be willing to play their essential part in a training partnership between themselves, the training establishments and the National Council for Social Work Training.

887. In the previous chapter we described the existing university social science and professional courses. We were glad to learn from the Joint University Council that universities providing professional training, including generic casework (applied social studies) courses, would be willing to co-operate with the local authorities in arranging field work placements for students in health and welfare departments, provided that supervision of the desired standard could be made available.

888. Substantial supervised practice is an integral part of the training for social work. We accordingly **recommend** that the central government departments concerned should request local authorities and regional hospital boards to consider giving a high priority to providing facilities of the required standard for students taking a recognised training for social work under either university or other auspices. This will also be an effective way of recruiting professionally trained social workers to the local authority services. In due course some of these would themselves become training supervisors. We hope, too, that appropriate voluntary organisations will be prepared to extend opportunities for field work at the necessary standard.

889. The general training courses which we advocate would be a pioneer venture. We have recommended that they should be mainly provided in colleges of further education, but we hope there will be a good deal of experiment. For example, some parts of a course might perhaps be taken in common by health visitors, social workers and occupational therapists, as well as by residential staff of various kinds. The joint discussion of case records (not necessarily social work records) might be one way of doing this. Such joint discussions during training can be an important means of bringing about that common knowledge of each profession's essential function, the inter-relation between them, and the point at which each becomes 'lay' in relation to the other, which is essential to real team-work and effective operation of the services. Perhaps in due time provision may exist in the same colleges of further education for those who are training for a variety of occupations in the field of education, health and social work. We would also hope that colleges offering such courses would be linked with the universities as teacher training colleges are now linked through the university institutes of education (see paragraph 885).

Admission requirements

890. We would regard 19 years as the minimum age of admission ; and the general certificate of education at ordinary level (or its equivalent) in appropriate subjects as the minimum educational qualification. We do not propose a rigid upper age limit. We assume that candidates for admission to any of the courses leading to the certificate would be individually interviewed by the staff of the course (assisted if need be by the National Council) and selected on the grounds of their qualifications and personal suitability.

The content of the courses

891. It would not be appropriate for us to make detailed proposals about the syllabuses to be designed by the National Council for Social Work Training. Accordingly, we confine ourselves to the following comments.

(i) The courses should be based upon an integration of theory and practice, rather than upon theoretical studies and short periods of practice not closely related to each other. This we regard as quite fundamental. Otherwise students would be turned out full of general knowledge which they are unable to use in practice, or else as technicians working by rule of thumb methods. In either event the result would not adequately justify the expenditure involved. The reason for training is that it can equip people who, because they have a common body of knowledge and skill, are able to do a better job—in range and depth—than the untrained. But this will only happen if the training itself is so planned and run as to achieve the aim in view.

(ii) The integration of theory and practice calls for careful analysis of the knowledge and skill which social workers require to use in their work. This must then be translated into the theoretical and practical content of the course ; and the balance between different subjects, the weight to be given to different aspects of each, and between theory and practice agreed. The course should be based upon the general principle that knowledge which is quickly applied

becomes more deeply ingrained, while skill is developed through both systematic study and guided practice. The whole course should also be planned to develop and deepen those attitudes of respect and concern for people in trouble, and the realistic desire to help them, on which social work is based.

(iii) The essential purpose of practical training (field work) is to help students to relate the knowledge from the background and methods courses to actual practice so that they may develop the skill in case study, social diagnosis and social remedial action characteristic of modern social casework (and also, in different forms, of group work and community organisation). This involves field teaching (supervision) by qualified social workers with an interest in teaching and who are themselves good social workers. They must know what is being studied at the training establishment and be able to relate this to practice in the students' work with individual cases. We say more (paragraph 898) about these requirements. It is well-nigh essential that the theory and practice should run concurrently with each other (though on different days of the week), because otherwise it is much more difficult to relate them effectively. This means that the departments used for training should be within reach of the training establishment. In order that students should begin to develop some real competence they should remain for at least five to six months in the same department and under the same supervisor during each field work placement. During their training they should have not less than two such field work placements in different departments (if possible) and under different supervisors. It will usually be desirable either to provide a third placement or else to increase the length of one or both of the other placements. Students should carry a small case load which they will work on and study thoroughly; they should have actual responsibility for these cases and for making all the necessary administrative arrangements in relation to them, in consultation with their supervisor.

(iv) So far as actual subject matter is concerned, we would regard the purpose of the course as being to give the students a good understanding of:

(*a*) human needs, motivation and behaviour. It is particularly important that students should have a sound general grasp of how human beings function in their physical, psychological and social aspects. This will include the chief phases of the life cycle from birth to old age and death, the importance of family and social relationships, the major human drives and motivation, the nature and effects of various handicaps and disabilities and especially their effect in creating stress and isolation. It will also be necessary for students to know sufficient about health and disease to recognise, and have some understanding of, variations within the normal as well as deviations, particularly as manifested in mental and physical handicaps, mental illness (neuroses and psychoses), 'problem' family living and unmarried parenthood:

(*b*) the social and economic circumstances in which people live including elementary knowledge about the ways in which the national income is made and distributed; employment (with particular reference to the disabled); levels of living; family budgeting; patterns of family life; housing; leisure; and the part played by various voluntary groups and associations in the life of the community. The social structure and social attitudes should be primarily studied from the standpoint of different social influences on individual behaviour, as well as community attitudes towards various forms of handicap and disability:

(*c*) the social services, statutory and voluntary. This will include the services provided by central and local government, the history, structure and methods of operation of the major services of social security, employment, education, housing, health, welfare and the children's services. It should also cover the various forms of social care and treatment, as well as the important part played by voluntary organisations in total social provision and experiment. The health and welfare services would of course be studied in a good deal more detail than the other services. The principles and practice of administration should be taught specifically at every appropriate point in the theoretical and practical parts of the course. All the foregoing subjects should be taught in close relation to each other.

(v) Much of the material may be applied more directly and precisely (through case studies and otherwise) in the teaching of:

(*a*) the principles and practice of social work. This subject would include the place of social work in the statutory and voluntary social services, and its philosophy and working methods. It will also include the essential characteristics of social work, as mainly concerned with failures in personal and social functioning, and as it is practised through the methods of casework, group work and community organisation. The main emphasis would no doubt be on considerable study of the theory and practice of casework. This would be related to the practical work on the one hand, and on the other it would be used to focus the background subjects. It would thus serve to make more specific and realistic the student's understanding of people in distress through handicap, illness and other causes, and their family, social and economic circumstances, the services available to help them, and the ways in which and the points at which social work methods can be used for this purpose. This teaching would be based upon study of casework method as applied in situations of increasing difficulty. This would also be an effective point at which to teach good administrative practices and the team-work which we regard as being of special importance in the health and welfare services. We hope that future social work students will also learn something about group relations and community

organisation as well as about casework. We think this is particularly important in regard to centres for the physically handicapped, clubs for the mentally disordered, workers in all forms of residential care (including temporary accommodation), hostels for unmarried mothers, the responsibilities of home help organisers, and the encouragement of voluntary effort in many forms:

(*b*) other skills. Individual students should have the opportunity, according to their interest and aptitudes, to begin to learn handicrafts, moon and braille and communication with the deaf. In any event, it would be desirable for them to know something about the use of these with handicapped people, for example to study the different methods used to enable blind people to become or remain literate by braille or moon embossed type, and to understand the relative value of different systems suitable for education and as aids to employment, as well as systems within the capacity of the very aged. If their interest and abilities lay in craft work they would need, for example, at some stage to acquire special skill in teaching crafts to blind people by tactile methods. They should also study means of communication by touch used by people who are blind and also deaf. Other considerations would apply to the teaching of those who suffered from other types of handicap. Whether individual students begin to acquire these skills at the training stage or develop an interest at subsequent points in their career, they should be enabled to improve their proficiency by further training and experience later. This would include both skill in the activity and skill in teaching.

(vi) The tests used for granting the qualifying award must be related to that which they are designed to test. For example, although set examinations may be used to test a certain range of knowledge they cannot test proficiency in field work. It would be for the National Council for Social Work Training to pursue this problem further in relation to the standards required for a national award. No doubt more than one test would be used, as at present in various training courses. We hope that the best educational advice would be sought on this important matter. It is essential that the award should command respect. This it will do only if it denotes a good standard of work and achievement. Even so, the proof of the pudding is in the eating, and the real test will lie in the students' subsequent performance. It is for this reason that periodic evaluation of the training courses themselves and of the students who have qualified through them will be of great importance.

Specialisation and training

892. We have discussed specialisation in employment in Chapter 6, with particular attention to the non-specialised social worker, where we envisage that local authorities will experiment with various groupings of functions. We consider that the main trend should be away from the employment of specialised officers for various types of handicap and towards a combination

of functions. In accordance with these conclusions, we are in broad agreement with those witnesses who thought that there should be general training with the possibility of later specialisation by experience. We are not ourselves in favour of a multiplicity of separate specialised trainings, which are largely the result of piecemeal development. We would only regard specialisation as more advanced if it followed a general training and was in fact at a higher standard. Our own view is that all students should be given the broader understanding of individual development and social functioning, and of the structure and operation of the social services which we have indicated (paragraph 891). We think it is of fundamental importance that students with a university or other social work qualification should have a good general training which would make them free to transfer from one field to another if they so chose during their working life, or would leave them equally free to specialise in later employment if they wished to do so. We regard this common training as an important means of bringing about future co-operation between social workers in different services. In this general training students would learn a good deal about handicapped, elderly and ill people, and those with social problems, and have substantial field work experience with them. It should also be possible for students to study particular aspects in greater depth.

893. Some fears may be expressed that this would result in a less good service than at present for particular classes of handicapped persons. This is not our intention. As we have said, in discussing the purpose of social work, the personal and social effects of various handicaps have much in common; we would envisage that in a general training similarities and differences would become all the sharper by being discussed in relation to each other. We have no doubt that the National Council, in approving syllabuses, would be at great pains to ensure that more detailed knowledge of and opportunities for substantial field work with each main group of physically, mentally or socially ill or handicapped persons within our terms of reference were provided in the training course, so that students might at certain points in the course concentrate on particular interests. The training we propose would be at a very much higher standard, from the point of view of length and training resources, than has hitherto been possible in the present specialised trainings for work with the handicapped. We therefore feel confident that our training proposals, coupled with our proposals for the future staffing of health and welfare departments, would result in progressively raising the standard of service to all types of handicapped people.

894. We **recommend,** accordingly, that the general training should also provide opportunities for more detailed study in line with a particular student's bent. For example, we think it necessary for all students to have a rudimentary knowledge of mental defect, and of the various forms and manifestations of mental illnesses, as part of their general study of human growth and development. But students especially interested in this field would no doubt carry this study further and have one or more field work placements in the mental health service. They, like others, should later in their careers take refresher and more advanced courses as these become available. Normally, mental welfare officers would also continue their training through regular psychiatric consultation and, where possible, by supervision by a psychiatric social worker. We think that mental welfare officers

with a general training should not, if it can be avoided, be appointed to posts where facilities for such consultation do not exist until they have already worked under supervision, or with regular consultation, for at least a year.

895. Students particularly interested in work with the blind should have appropriate theoretical and practical studies and field work during their training. Those who wished to develop skill in teaching should, as we have said, have opportunities during the course and subsequently to study braille, moon and handicrafts. Students with the necessary aptitude should begin to learn to communicate with the deaf, and to gain more understanding of the psychology of the deaf. While we think it desirable that these general opportunities should be available, we do not wish to suggest that students must necessarily express a preference for, and commit themselves to, any particular one of various options. But we think it important that facilities to carry knowledge and skill to a more advanced level should be available to social workers at a later stage in their careers. We recognise that constant practice and experience would be an important element in this, for example in attaining reasonable fluency in communication with the deaf.

896. We very much hope that the National Association for Mental Health, and the organisations which now train and examine those who wish to work with the blind or deaf, would be prepared to co-operate in training courses, especially with refresher and advanced courses. It appears to us that much of the knowledge and skill now gained through experience needs to be further systematised. A good deal has been done to systematise what students need to learn about 'teaching the blind to be blind' in their own homes and neighbourhood, but there is room for further advance as new methods develop. Communication with the deaf really means learning a new language. Without wishing to engage in the oral/manual controversy, we think the fact that workers with the deaf do at present actually have to become proficient in sign language indicates that this too should be systematised and taught intensively. We hope that the voluntary organisations concerned will work with the National Council and with educationalists with experience in other fields to devise means of training which would give greater skill in a shorter time than at present. We would also hope that the National Association for Mental Health and the Association of Psychiatric Social Workers would assist with those parts of the syllabuses which relate to mental illness, mental defect, community attitudes to mental disability, and social work with emotionally disturbed or defective people, and that the Institute of Almoners would give similar help in its sphere.

Length of the general training courses

897. The length of the general training courses for the National Certificate in Social Work must be governed by what is practicable on the one hand, and on the other hand by the time it takes to produce the desired results. We have laid great emphasis on the subject matter being studied 'in the round' in the various aspects which go to make up the total field of study; and on theory and practice also being interwoven as twin aspects of the whole. This approach seems to us to be in accord with reality. We are also convinced that students well taught in this way do in fact learn more

quickly, assimilate their studies more deeply, learn to make more intelligent and selective use of their knowledge, become more readily skilled in its application and go on learning in their after careers because certain principles and ways of working have become ingrained. The curriculum we propose (paragraph 891) is a heavy one. Some, at least, of the subjects which we outline (paragraph 891 (iv) and (v)) should be taught throughout the two years, so that the students may have a thorough grasp of them. We also think that supervised practice in the field should occupy about one-half of the total time. It is generally recognised that professional education involves not only assimilation of knowledge but also development of the appropriate skill and attitudes. This kind of learning is, in its nature, slower than purely intellectual learning. We think, therefore, that good selection and good curriculum planning will be essential, in order to achieve these objectives in the general training courses. We are convinced that it could not be done effectively in a shorter period than the two years full-time (or its equivalent) which we recommend. Indeed this may be regarded by many as too short when it is remembered that, to refer to comparable fields, the two year teacher training is to be lengthened to three years, and that the training of a health visitor takes four years and of an occupational therapist three years.

898. In planning the two year curriculum of the full-time general courses for new recruits to social work, we would distinguish participant observation in the field from actual practical work under supervision for the purpose of developing skill. Such observation we would regard as the first stage as the student learns to apply his studies in real life. This participant observation on one or two days a week would include aspects of the work of a local authority, observation of people of different ages in different circumstances, and of the general structure and social resources of a neighbourhood and so forth. It would of course flow from and be fed back into the theoretical studies, and would be followed later by the two or three substantial field work placements discussed in paragraph 891 (iii).

899. The question of part-time study for those already in local authority service is a difficult one. Nonetheless we think that with imaginative planning it would be possible to cover some of the initial ground for the National Certificate Course by day-release courses interspersed with periodic full-time study. The danger of part-time courses, unless they are carefully thought out, is that they tend either to become isolated academic studies which the students do not relate to their work or to their understanding of the real world, or else they may be purely instructional courses in which facts are learned without any intelligent attempt to analyse the principles behind them or to relate them to other subjects. We think it is essential to plan day-release courses in such a way that they engage the students in thinking imaginatively about their own work and in relating it to study of the subject matter which we have outlined (paragraph 891). The case loads of officers taking this part-time portion of the course should be lightened, in order to give them time for attendance at lectures, for reading, and to record one or two cases in detail for further discussion. Part-time study can be made much more effective by a combination of day-release interspersed with periods of full-time study, preferably in residential colleges. We go into this in detail in paragraphs 918 to 921.

900. In those authorities where supervision (field teaching) is available it should not be unduly difficult to meet these requirements. In others a certain amount of the necessary supervision must be provided by the training establishment. In saying this we are assuming that, as time goes by, both full-time and part-time courses would normally be run by the same educational establishment.

901. We do not feel able to lay down any hard and fast rules about the equivalence of part-time to whole-time studies because this would depend on the amount of weekly part-time release, the length of residential periods and the field teaching available. As a generalisation (but depending upon circumstances) we would think that either three or (in more favourable conditions) two years of part-time study of the kind we have outlined could be regarded as the equivalent of one year of full-time study. Correspondence courses could play a part where students come together at regular intervals for group study and then disperse, with further set studies to undertake. This safeguard would meet essential conditions not always covered by correspondence courses; for example the possibility of group discussions, which we agree with the Joint University Council should be regarded as a necessary element in training. We consider more fully in paragraphs 918 and 921 the various means by which some of the total course might be taken by part-time release. In any event, we do not think the period of full-time study (Part II of the course) following part-time study (Part I) should take less than one year. We are convinced that students would gain most from full-time study in their last year when a good deal of ground work has been laid: thus it should not be possible to take the entire course by part-time study, or to reverse our suggested order.

902. The pattern for the award of the National Certificate in Social Work (apart from the one year full-time course recommended in paragraph 915 as a temporary expedient for selected officers) would thus be:

(*a*) (for new recruits and for some present officers) full-time study for two years (Parts I and II), or

(*b*) (for present officers only)

(i) part-time study for either two or three years by day-release on one or more days a week, with full-time residential or non-residential periods, and a lightened case load (Part I), followed by

(ii) full-time study for one year (Part II)

Assessment for the National Certificate in Social Work

903. The qualification would, no doubt, be awarded by the National Council on all-round performance in examinations, essays, class discussions and field work (see paragraph 891 (vi)). It would follow that only those who have successfully completed Part I of the course for the Certificate would be eligible for admission to the one year full-time course for Part II. The award for the first might be entitled the Intermediate Certificate in Social Work, and for the second the full National Certificate in Social Work.

904. As we have said (paragraph 870 (*b*)) it is essential that the qualification should be of sufficient standing to be recognised by the Local Government Examinations Board and by the appropriate National Joint Councils. We hope also that the general courses would be worked out with the univer-

sities at such a standard that the best of those who complete them could be admitted at a later point in their career to the university one year professional (that is, post social science) courses if they so desired, with no more than the necessary minimum of additional academic preparation. We would also hope that some promising officers each year would be given leave of absence to take the full training described (paragraph 870 (i) (*a*)). Some others would no doubt resign from a particular post in order to do this (as happens at present) and return to local authority service when they had qualified. New entrants with the full university social science and social work qualifications would also, we hope, be recruited in increasing numbers. In addition, there will be some who have taken a social science qualification and are recruited, as at present, without further training. We discuss the training which they require in paragraph 931. We think that the general training courses, as they become established, would be taken by many suitable people who for various reasons could not take the university courses, but who desire to become social workers. We discuss the question of training for older serving officers in paragraph 924.

STAFFING

905. We suggest 30–40 as the number of students for a full-time course because we think this is the maximum for whom suitable field work could be found. In addition, there is the problem of accommodation in local authority and other offices. In some courses the number may have to be lower, at any rate in the earlier stages, for these reasons. As to staffing, we think that one social work teacher could be responsible for 15–20 students. This would include taking classes for them and also for their immediate supervisors in the departments concerned. It would be desirable for the social work teachers to give students some individual supervision on one or two cases, if they were working under the direction of inexperienced supervisors. If two social work teachers were appointed to a course with 30–40 students it would be possible for them, in addition to their work with students, to take regular classes on supervision in order to increase the available facilities in the area.

906. Some of the other lecturers could be part-time, provided they were able to give sufficient time to work out their courses in relation to each other so that the syllabus was planned as a whole, and with a view to integrating theory and practice. In addition to other full-time staff, there should be a tutor or director in charge of the whole course, with administrative and educational responsibilities, who should also teach in the course and thus be in close contact with the students.

SUGGESTIONS FOR MEETING THE SHORTAGE OF SUPERVISORS

907. The shortage of qualified social-workers able to undertake field teaching (supervision) is a major limiting factor in any rapid expansion. 'Training the trainers' presents considerable difficulties because only those who are doing good casework themselves, and are able to impart it to others, are competent to teach in this way. We think, therefore, that varied means must be used to produce the necessary corps of field teachers. One of the first essentials is to attract into the local authority health and welfare departments as supervisors some of the few who already exist. In order, however, not to waste resources these appointments should be made in conjunction with training courses. Consideration should be given to part-time appointments if suitably qualified persons could be recruited in this way. We also

recommend that local health and welfare authorities should pursue a vigorous policy of recruiting officers who have recently completed one or other of the professional courses enumerated in paragraphs 822 to 826, in order that some of these might become supervisors when they have had sufficient experience.

908. While the number of supervisors remains so small, they will probably have to be used to take group discussions on casework rather than for individual supervision. We would, however, hope that wherever possible, each student should be individually supervised on at least one case. We know of no other means so effective for putting theory into practice.

909. We are well aware that for years past lack of facilities for field teaching has been the main hindrance to increasing the number of students taking the present professional courses ; and that the best possible deployment of existing resources and the most active co-operation by certain local authorities is needed in order to bring into operation the expanded training which we envisage. This will inevitably mean that some officers whose services are also urgently needed as caseworkers must be used as field teachers. But it is only by baiting a sprat to catch a mackerel that the necessary expansion will be possible. We do not doubt that there will also be found to be a shortage of suitably qualified teachers for the other subjects which we suggested in paragraph 891 should form part of the curriculum. But we do not think that this shortage is likely to be quite so great as that of field teachers in social work.

910. It would also be necessary for those who are doing the day-to-day supervision of students themselves to attend courses in supervision. This should preferably take place for a time before students come (see also paragraphs 905 and 916).

SHORT-TERM AND LONG-TERM PLANS

911. It would not be possible to implement the whole of our proposals straight away on account of the dearth of teachers and supervisors, and also because officers holding social work posts could not be released in sufficient numbers to take the whole of either the university or the general training courses. For the same reason, it would not be possible to make in-service training and refresher courses immediately available universally.

912. The most vigorous efforts and planning by the Ministry of Health, the Department of Health for Scotland, the local authorities, the universities, the relevant voluntary and professional organisations, and selected colleges of further education, will be essential if well thought out, rather than piecemeal, training is to be got under way. This presupposes that the National Council for Social Work Training is brought into existence at an early date, charged with the responsibility of working out a general plan and securing its implementation.

913. We regard it as quite essential that any short-term plans which might be brought into operation should be such as to dovetail with and lead into long-term plans. This means that one structure not two must be created. The plans outlined below are thus designed as a means by which training might be started, and progressively extended, to permit present officers and new recruits to take the proposed courses for the National Certificate in

Social Work. The plans we suggest below for day-release and residential part-time courses would provide varied means of preparing those already in local authority service for Part I of the Certificate.

914. In view of the requirements of the local authority mental health service, we **recommend** that a high priority should be given to the release of mental welfare officers and duly authorised officers to take these courses. We regard the training of welfare officers as hardly less urgent. It is also necessary to pursue a vigorous policy of new recruitment for the two year courses.

915. In addition, we **recommend** that in the present emergency situation, where much leeway has to be made up, specially selected welfare officers and mental welfare officers with good educational qualifications should be released by local authorities and accepted to take a one year full-time course leading on successful completion to the award of the full Certificate. This course, which should be distinct from the others recognised by the Council, should be specifically planned and staffed for the purpose. It would be designed to meet an urgent need, and should on no account run for more than five years.

916. High priority should also be given to conferences or refresher courses for senior officers (particularly chief welfare and deputy chief welfare officers) at which they could discuss with experts various aspects of modern social work methods and practice, in order that they might help and guide their staff as training is introduced. Another high priority would be courses for future supervisors and teachers both in the general training courses and for in-service training. Such courses are the key to the development of training because it will only be possible to expand long-term training as sufficient experienced and qualified social workers become available to teach and supervise students. These training courses for supervisors and social work teachers would have the combined aim of improving social work skill, systematising the body of knowledge which underlies this skill and relating both to good educational method.

917. We summarise in Table 31 our proposals for training leading to a qualification in social work.

Provision of part-time two year courses

918. We envisage that it should be possible, with the full co-operation of everyone concerned, to start three two year part-time courses fairly quickly and a further four to six while the earlier courses are in their second year. In one or two areas this might be done by a second intake in an existing course: in others by starting a new course in a different part of the country. These courses could draw on the surrounding local authorities for students (that is, officers holding posts in the health and welfare departments). The case loads of these students should, as we have said, be lightened so that they may do the necessary reading, essay writing and case recording. These should be day-release courses, with two residential (or whole-time) weeks a year. The syllabus should cover part of the ground already outlined. Each course could take up to a total of 30 students, that is to say an annual intake of 15, provided that for teaching purposes the total 30 could be divided into two classes. We have discussed staffing in paragraphs 905 to 906.

Table 31: Proposals for training leading to a qualification in social work

Nature of training	Application to		
	Present officers	New entrants without a social science degree, diploma, or certificate	New entrants holding a social science degree, diploma or certificate
I. *University social science and professional courses.*	Leave of absence (normally for those qualified to take a one year professional course, but from time to time also to take a social science course followed by a professional course).	Grant aid[1] to enable suitable candidates to take a full training.	Grant aid[1] to enable suitable candidates to take a one year professional course.
II. *The National Certificate in Social Work* (*a*) Part I for the Intermediate Certificate.	Either (i) a full-time one year course or (ii) a two (or three) year part-time course with day and other release by means of the urban and adjacent rural centre courses, or the intermittent course for those in isolated rural areas.	Grant aid[1] to take the two year full-time course for both parts of the certificate.	Deemed to have substantially completed the requirements for Part I.
(*b*) Part II leading to the full Certificate.	(i) A one year full-time course following on successful completion of Part I *or* (ii) a special one year emergency course for selected officers who would on successful completion receive the full Certificate. This course is intended to help make up arrears and should not be available for more than five years.		Grant aid[1] to take a one year full-time course for Part II only.

[1] For our recommendations about grant aid see paragraphs 935–939.

Part-time training in rural areas

919. Various imaginative devices are required to meet the needs of rural areas, which present special problems. For the most part we see no reason why the day-release course we envisage for large cities and their environs should not be made available at convenient centres in scattered areas by means of a travelling team of lecturers. Sometimes this team might go from one centre to another on two or three days of the week. At other times, the lecturers in city part-time courses might be prepared to go to one or more adjacent rural centres on different days of the week. We think it unlikely that a full time casework teacher and supervisor would be able to take responsibility for more than 20 students in this way if he or she were expected to discuss individual cases, and also to help the students with their general studies as would be desirable.

920. We are well aware that these proposals for part-time day-release courses would not touch the needs of more remote and isolated rural areas, especially in Scotland, except where access to a suitable centre was possible. We would thus see a necessary place, both in short-term and long-term plans, for residential as well as day-release courses.

921. These residential courses should last for 10 to 15 days, and should be planned in relation to each other. Those who take them should attend three such courses a year. They should be regularly visited between courses by supervisors attached to the course and should be given certain work to do, for example, reading and preparation of essays, as well as recording a few of their own cases for discussion at the next course. These residential courses should be so planned as to make one course from the angle of the total curriculum. They should be open only to candidates who are not within reach of a day-release part-time course. Attendance over a two year period at six such residential courses, together with the required study and consultation between the residential periods, should lead on successful completion to the Part I qualification referred to above. As we have said, Part II should only be taken as a full-time course.

Provision of full-time two year courses

922. In addition to part-time courses, we think it essential that full-time courses for the National Certificate in Social Work should be started as quickly as possible, since these should be the means of providing general training for social work in the local authority health and welfare services in the future. Accordingly, we **recommend** that one full-time two year course should be started as soon as possible. As this would be the pioneer course, it is extremely important that it should be run under the best possible auspices, in order that the prestige of the course should be soundly established by setting a high standard from the beginning. The experience gained on this first course should also be available in running others as these come into being. A major purpose of this first two year course would be to attract new entrants to the service. It is, therefore, important that there should be good publicity for it, and careful selection for admission, since the quality of a training is naturally judged by the performance of those who have taken it. We would hope that the educational establishment which provided the first two year full-time course for new recruits would also be running a two year part-time day-release course for officers already in the service, and that there would be some interchange between the two sets of students. Some of the part-time course students, having completed Part I of the National Certificate in Social Work, could then join the full-time course for the final year. We would hope that about 15–20 students could be accepted each year for the full-time courses, that is to say, a total of 30–40 full-time students at any one centre, in addition to the part-time students in certain centres (see also paragraph 933). Provision for these numbers is, however, dependent upon the local authorities concerned, and also mental hospitals and other suitable public and voluntary agencies, being able and willing to make facilities available for field practice, and upon suitable supervisors and other teachers being recruited.

TRAINING PROPOSALS FOR OFFICERS ALREADY IN THE SERVICES

923. It is now necessary for us to equate our proposals for training for a qualifying award with existing qualifications, and to make recommendations for the further training of officers with various qualifications (including long experience). We then go on to estimate the number of present officers who would be eligible for training; and, finally, relate our suggestions to estimates of future demand in the services. We do not think it would be

realistic to make training compulsory for some years to come, but we think it essential that every inducement short of this, including financial help, as more fully described later (paragraphs 935 to 939), should be offered to local authorities and to officers in order that they may take full advantage of all available training facilities recognised by the National Council for Social Work Training.

924. We **recommend** that officers in the health and welfare services without a social work training, and over the age of 50 or with 15 or more years experience in a social work appointment, should be recognised from the date that the training scheme is brought into operation as qualified by experience. Many should be encouraged to take the appropriate refresher courses. Other officers over 40, or with more than 5 years experience, should (unless they hold a social science qualification) take part-time courses for Part I of the National Certificate in Social Work ; they should be eligible to take Part II, if so desired, and should be eligible for promotion even though they do not hold the full Certificate. Officers aged under 40 or with less than 5 years experience should (unless they hold a social science qualification) take Part I by part-time or full-time study, and go on to take Part II (full-time) : selected officers should be given leave of absence to take a university or other professional course in social work. Officers in this group who hold a social science qualification would normally be expected to take a university or other professional course : if, however, they wished to qualify for the National Certificate in Social Work they should be regarded as having substantially fulfilled the requirements for Part I of the Certificate. These recommendations with regard to training for officers already in the services are set out in Table 32.

925. We have tried to estimate how many present officers fall within the various categories described in Table 32, and in particular how many should take courses for the Certificate in Social Work. These estimates are based mainly on the replies to the questionnaire (summarised in Chapter 2) which relate to 1st May, 1956.

926. Welfare and mental welfare officers of all grades numbered about 1,850. With these should be considered about 100 home visitors for the handicapped and 250 administrative officers with some social work functions, or 2,200 in all. We estimate that of this number about 1,350 should not be required to take courses for the National Certificate since they are either over 50 years of age, or hold a social science qualification, or have had over 15 years experience in a social work post : that about 630 of the remainder are either aged between 40 and 50 years or else have had more than 5 years experience and thus should take Part I for the Intermediate Certificate. We hope that some would also be given leave of absence to complete Part II for the full Certificate. About 220 are under 40 and have had less than 5 years experience, and should, therefore, on our recommendation, take the full Certificate.

927. There are at present, in round figures, 800 home teachers of the blind, of whom we estimate that about 280 are under 40 years of age. We have no record of length of service but we estimate that some 250 of these will have had less than 15 years experience in a social work post and should thus take Part I of the Certificate. We hope that some of this number will take the full Certificate.

Table 32: Recommendations for further training of officers holding social work posts who are under the age of 50 or have less than 15 years experience

Designation of officer	Aged over 40 years at the date when the training scheme comes into operation, or under 40 if with 5 to 15 years experience	Aged under 40 years at the date when the training scheme comes into operation, and with less than 5 years experience	Irrespective of age
Welfare officers, mental welfare officers, home visitors for the handicapped, and administrative assistants (who do not hold a social science or professional social work qualification) Home teachers of the blind Welfare officers for the deaf.	Part-time courses for Part I of the National Certificate in Social Work.	To take Part I by full or part-time study. To be given leave of absence to go on to Part II (full-time) after passing Part I. To be given leave of absence, in individual instances, to take a university professional qualification.	Refresher courses.
Officers with a social science qualification.	—	To be given leave of absence to take a university or other professional course or Part II of the National Certificate in Social Work.	Refresher courses.
Social workers with a qualification as almoner, psychiatric social worker, family and generic case-worker.	—	—	Refresher courses and courses in supervision.

928. We understand from the evidence of the National Council of Missioners and Welfare Officers to the Deaf that about 150 workers with the deaf are employed by voluntary organisations. It is desirable that some of these should take the Certificate and we would suggest an arbitrary figure of 25.

929. Taking these figures as a guide, we estimate the total number of officers who should take courses for the National Certificate in Social Work as 1,125 ; of whom some 875 should take Part I and some 250 the full Certificate. We would hope that about 75 of the latter (15 a year over a five year period) would be given leave of absence to take the one year emergency course (referred to in paragraph 915) and a further number of younger officers (about 10 a year) to take a two year full-time course, rather than qualifying by means of the part-time course followed by the one year full-time course. We have little doubt that the educational gains from full-time study and practice are greater than when students are trying to satisfy the heavy claims of work and the exacting demands of study and practice at the same time.

930. Our estimates of the number of existing staff requiring training are summarised in Table 33. We would emphasise that these are minimum figures, particularly as regards the numbers who should take the full Certificate. We hope that these figures would in fact be exceeded.

Table 33: Officers in social work posts: estimated training facilities required in courses leading to the Intermediate Certificate and full National Certificate in Social Work

Designation of officer	Approximate numbers	Estimated numbers who should take courses for the Certificate in Social Work[1]		
		Total	Intermediate Certificate (Part I—2 or 3 years part-time)	Full National Certificate (Part I full-time or part-time; and Part II full-time)
1. Welfare and mental welfare officers of all grades ...	1,850	850	630	220
Home visitors for the handicapped	100			
Administrative officers with some social work functions	250			
	2,200			
2. Home teachers of the blind	800	250	245	30
3. Missioners and welfare officers to the deaf	150	25		
Totals	3,150	1,125	875	250[2]

[1] No attempt has been made to estimate the small number who would take the university or other professional courses, nor the numbers to be provided for in refresher courses.

[2] It is hoped that over 5 years about 75 of these officers would be given leave of absence to take the one year full-time emergency course (described in paragraph 915) and that a number of the remaining 175 be given leave of absence to take the two year full-time courses for the full Certificate.

TRAINING PROPOSALS FOR NEW RECRUITS

931. New entrants to the services will, in course of time, hold the National Certificate in Social Work, or a university or other related social work qualification,[1] before appointment as social workers. Alternatively, they would be employed initially as welfare assistants, and subsequently encouraged to take the full-time two year course for the Certificate. New entrants with a social science qualification would normally be expected to take a university or other professional course. If, however, they wish to qualify for the National Certificate in Social Work they should be regarded as having substantially fulfilled the requirements for Part I of the Certificate.

932. So far as new recruitment is concerned, our training estimates must be related to calculations about the need for replenishment due to wastage (retirement, marriage and change of employment) and to estimated expansion of the services. The estimates in paragraphs 782 to 801, and in Table 28, show that it will be necessary to recruit about 260 officers a year for replacement, and about 250 for expansion of the services, or 510 in all, exclusive of social workers with a professional qualification and of welfare assistants.

[1] For enumeration of existing qualifications see paragraphs 816 to 827.

Allowance must be made for losses by withdrawal from courses and failure. Taking this into account we calculate that about 570 students a year should be recruited for training for the full National Certificate in Social Work. Some of these students will be young men and women already in local authority service who desire to become social workers. Although we hope that for them—as for other new recruits—the two year full-time course will be the usual form of training, they should be eligible to take part-time courses for Part I of the Certificate. If we assume that annually about 40 such officers take part-time courses for Part I and that about 10 untrained officers in social work posts (see paragraph 929) take the two year full-time course, it would be necessary to provide for an annual intake to the first year of the two year full-time course of about 540 students. Allowing for wastage we calculate that about 510 of these will pass on to the second year full-time course. To this number should be added the 40 officers discussed above, who will have taken part-time courses for Part I, before joining full-time courses of Part II. Allowance must also be made for younger officers (numbering perhaps 20 or 30 each year) who have been given leave of absence from social work posts to take Part I by part-time study and Part II by full-time study. In all, therefore, provision must be made for about 570 students to take full-time courses for Part II of the National Certificate for Social Work.

933. We do not think any one course could absorb more than 15–20 students a year (30–40 in all). This means that about thirty full-time courses should be provided, as it becomes possible to do so, for the country as a whole. In addition, we calculate that nearly 200 officers would be taking the various part-time courses at any one time. The two sets of students would only compete for field work placements where full-time and part-time courses were run in the same area. In the largest cities this would be inevitable.

934. Given good planning we think it should be possible to make provision, within about seven years, for the number of students we envisage. It will, indeed, be essential to do so, in order to take advantage for recruitment purposes of the 'bulge' in population, and to staff the expanding services adequately.

GRANT AID, TRAINING GRANTS, AND OTHER INDUCEMENTS TO TAKE TRAINING

935. We have described (paragraph 842 to 848) existing provision for grant aid for students taking social science and professional social work courses. We agree with the evidence we received that this is not adequate to meet existing requirements. We very much hope that all authorities will act generously in supporting suitable applicants for grand aid, and that they will adopt a more liberal policy regarding the extension of awards for graduates, including those who are already graduates in other subjects. One year courses of professional training are, for many students, essential complements to the university courses in social science, and we sincerely hope that local education authorities will be prepared to give financial assistance to suitable candidates for such courses. We also hope that employing authorities will be prepared to grant extended periods of leave on full pay to selected officers, and to take fuller advantage of the scheme for post-entry training of the National Joint Council for local authorities' administrative, professional, technical and clerical services.

936. At the same time, we do not think that existing provision, however generously applied, will suffice for training on the increased scale which we recommend. To attempt to secure grant aid by separate correspondence with a number of local education authorities would place an impossible burden on those administering the training courses, while candidates would be likely to withdraw if they had to face the uncertainties of not knowing until the late summer whether or not they would receive a grant. We thus regard a national provision of assured grant aid as an essential element in both training and recruitment. The present situation, as we have described it, calls not only for the training of a much larger number of new recruits than hitherto (and good candidates are exceedingly scarce) but also for the release for training of numerous officers, many of them in mid-career, often with family responsibilities. Adequate inducement must be given to local authorities to release officers whose services they can ill spare, and also to officers to encourage them to apply for training. In these circumstances assured financial assistance is essential. We **recommend** that grant aid from central government funds should be available to individuals for training in social work in the health and welfare services, as it is already for those who intend to enter the probation or child care services. We understand that legislation will be required to enable Exchequer funds to be employed to finance training and refresher courses, and to grant aid students accepted for the general training, for a university social science course or university or other professional training, or to take refresher or advanced courses. We **recommend** accordingly as a matter of great urgency that legislation for these purposes should be introduced, giving the Minister of Health and the Secretary of State for Scotland powers broadly similar to those of the Home Secretary under the Children Act, 1948, and the Criminal Justice Act, 1948.

937. It would not be within our terms of reference to make proposals about 'uncommitted' grants in line with the Joint University Council evidence, nonetheless we hope that anomalies will be explored by all those concerned, with a view to evolving a more satisfactory general system of grant aid for social work training.

938. In addition, we think that potential students should be better informed than at present about the financial assistance available and how it can be obtained. We suggest that one of the functions of the National Council for Social Work Training should be to keep the subject of grant aid under continuous review and to include information about it in recruitment activities.

939. Finally, as an inducement to present officers and new entrants to undertake training, we **recommend** that some financial recognition should be given on successful completion of a recognised course.

IN-SERVICE TRAINING

(a) General

940. In our view far more systematic provision is required than exists at present for in-service training. We use the term in its broadest sense to mean: "every method used by an agency to improve the quality of service rendered by the agency staff or by any particular section of it, as well as similar aims pursued by professional and other associations, by schools of

social work, and by other educational institutions which are attended by persons performing a social welfare function ".[1]

941. This involves the planning by senior staff of regular opportunities for different forms of in-service training for members of the social work staff, whether these are run by the authority or provided elsewhere. This training would include attendance at refresher courses, conferences, lectures, discussion groups and certain case conferences. A number of films exist which could be effectively used from time to time: they should be well presented, and should always be followed by discussion in order to derive the maximum benefit from them. In addition to these commonly recognised forms of in-service training, greater use should be made than at present of well planned staff meetings, field work manuals, bulletins and a staff library as means of continuous in-service training. Staff meetings will usually be concerned with a number of day-to-day matters but they may also profitably include periodic talks and discussion on some subject of direct interest, given by persons outside the department or by one or more members of the staff who prepare material on different aspects of a subject and present it for discussion. Special emphasis should be given in such sessions to relevant new legislation, circulars or reports of government or other inquiries. Staff manuals or working lists, containing factual and other information which is regularly brought up-to-date, are a useful element in in-service training. Some parts of such manuals may be prepared and revised by the staff itself. We also think much more might be done than at present to make books and periodicals in the broad field of social work or social welfare available to staff, and to encourage them to read and from time to time discuss these. Some authorities may think it desirable to delegate specific responsibility for working out, and securing the implementation of, a plan for in-service training. The advice of the education department will no doubt be sought on some of the educational devices which might effectively be used in such schemes. The National Council for Social Work Training should assist authorities in planning such training when desired, in addition to providing courses for staff supervisors.

942. It is extremely important that all newly appointed staff should be given systematic in-service training, rather than being left to 'pick up the job' as they go along. This should include a planned period of orientation to the work of the local authority. This is necessary for those who have had a professional training in social work as well as others. Newly qualified and appointed social workers should work under supervision for a time, with regular periods for discussion of their cases with a trained social worker qualified to supervise.

(b) **For welfare assistants**

943. For welfare assistants we **recommend** in-service training in local authority departments on the following lines:

(i) A planned induction or orientation course lasting initially for a few days, in which the trainees are introduced to different aspects of the local authority's work by means of talks, visual aids and visits

[1] *In-service Training in Social Welfare.* United Nations Publication, Sales No. 1952, iv. 9. p. 1.

to different departments. This would include discussion in greater detail of the work of the department, the kinds of people for whose needs particular services are provided, how these operate and what are the functions of officers with various qualifications. The trainees might at this early stage also study and discuss one or two case records from the point of view of what they would need to know and to observe about a case ; and in relation to the principles and practice of social work.

(ii) The trainees should quickly start to visit in connection with a small case load of their own for which they would take increasing responsibility as training progresses. They should have ample opportunity for planned discussion of these cases and the work to be done on them.

(iii) The course should continue on one or two days a week with discussion classes on the essentials which the trainees need to learn about the department and their own work, about human relations and particularly about the needs, outlook and life of handicapped or elderly people, whether in families or living on their own. This would include some simple knowledge about social and economic circumstances.

(iv) So far as possible, factual material should be made available in written form. A working manual on the structure and functioning of the particular local authority and the procedures observed in the department would be particularly helpful to trainees.

944. It is probable that the essential ground could be covered in planned courses of six to eight weeks' duration, provided that good teaching was available, that supervision and guidance could be provided subsequently, and also that there were opportunities for further in-service training later. These courses assume recruitment of workers at this level in groups, and that there will be a qualified staff member in charge of the course. Smaller authorities might combine to run these courses and would also rely on help from larger authorities. Various alternatives, including 'sandwich' courses, would be possible.

945. We have referred (paragraphs 837 to 841) to the different forms of in-service training. We would hope that the National Council for Social Work Training would give a good deal of help to local authorities in planning the necessary in-service training for welfare assistants, and would run courses for those who will be responsible for this training. The National Council's own staff should also be available for consultation on the planning of syllabuses, and to suggest teaching material and devices, for example suitable visual aids.

TRAINING FOR RESIDENTIAL STAFF

946. We have said that, in our view, the work of some staff of residential establishments contains a social work element, especially in group relations. It seems clear that residential staff need to have an understanding of the reactions of people in group situations, and to know how to bring about richer and more satisfying group relations as part of the life of the residents. The functions of residential staff in the various services with which we are

concerned vary considerably but we hope that in course of time, as qualified social workers become available in increasing numbers, some will take employment in certain of these posts. In the meantime, appropriate staff of residential homes should be encouraged to take existing training courses such as those organised by the National Old People's Welfare Council for wardens and matrons of old people's homes, and to attend suitable refresher and other courses. In time they should be eligible for any suitable training provided under the auspices of the National Council.

REFRESHER AND OTHER SHORT COURSES

947. We see an important place for refresher courses of all kinds. It should be recognised that these are complementary to, rather than a substitute for, a university course or the general training in social work. Refresher courses are particularly necessary for married women with a professional social work qualification who wish to re-enter social work after some years absence. One of the functions of the National Council for Social Work Training would be to publicise particulars of suitable courses being run under various auspices.

948. We envisage that the National Council for Social Work Training would itself sponsor the provision of various short courses in which practising social workers would carry further their interest in some particular aspect of the work, for example with old people, epileptics, 'problem' families or mental defectives, as well as to improve their general knowledge and skill. This would be analogous to the many short courses on particular subjects at present available for teachers. We have referred (paragraph 916) to the need for refresher courses for senior officers. These might conveniently take the form of day or residential courses lasting for 5 or 10 days, with the main emphasis on current developments and needs in the services and on social work practice. We also think it essential that regular part-time or full-time refresher courses for supervisors and casework advisers on similar lines should be provided in various parts of the country. A further need is for intensive courses in various related skills, for example, communication with the deaf.

THE CASE FOR A NATIONAL STAFF COLLEGE

949. We have repeatedly stressed the necessity to treat training as a matter of extreme urgency, and have recommended a National Council for Social Work Training to ensure the provision of training, to work out initial plans, plan syllabuses and lay down conditions for the qualifying award, and to institute active recruitment. The Council itself would not undertake training, except in the ways we have indicated. We therefore **recommend** that a national training centre or staff college should be established. We do not think of this as supplanting the regional arrangements which we have suggested (paragraph 885), but rather as providing the necessary stimulus and practical help required to bring them into being and to pioneer training in this field. We also think of such a centre as an important means by which the work of the National Council for Social Work Training could begin to become effective in the earliest stages. We could see them working in close co-operation with each other, although their functions would be different.

950. Our general recommendations in regard to training require fresh legislation, in order to make the necessary financial aid available. But in view of the immediate needs of the situation, we would hope that a charitable trust would be prepared to consider financing an experimental national staff college such as we propose. We have no doubt that the contribution to the social services (whether public or voluntary) which would be made by such an institution would go far beyond our terms of reference. So far as our proposals are concerned, we suggest that it should fulfil the following purposes :

(*a*) Provide a forum for discussion, consultation and small conferences for senior administrators and others on aspects of social policy and planning, and on modern social work method.

(*b*) Provide intensive training in casework and supervision for selected officers (particularly in the mental health service), who would then act as a nucleus of supervisors in their own departments, under guidance by personal visits from and correspondence with the college staff.

(*c*) Provide the first part-time day-release and residential courses for Part I of the National Certificate in Social Work.

(*d*) Possibly provide a pioneer two year full-time course.

(*e*) Pioneer a training in group work and community organisation. At present, there are no facilities for such training in this country, except to a limited extent for youth work. We regard this training as highly desirable for workers with the handicapped, for home help organisers, for some staff of residential institutions, and for more senior officers, who must learn how to mobilise community resources on behalf of mentally ill and mentally or physically handicapped people and to keep them, as well as old and difficult people, part of the community. Much work with the handicapped, whether at handicraft centres or in clubs, necessitates a knowledge of group relationships and of how to help individuals to get the greatest possible satisfaction from their membership of the group. In the long run, when experience has been gained and teachers become available, we would hope that all those taking the two year course would have some training in the use of these other social work methods.

(*f*) Collect case records and other teaching material, and make these available to other courses, as they come into being, and in co-operation with the National Council.

(*g*) Make a thorough and continuing study of the design, content and teaching methods of the various courses suggested above, from the point of view of using the best possible educational method. In connection with this, there should be regular follow-up of students, in order to evaluate the courses and the initial student selection methods. All this material should be available for use by the National Council and by those planning other courses of all kinds.

951. Such a staff college would require several social work teachers and supervisors on its staff. From what we have said, it will also be clear that we think it should have available the services of persons skilled in educational

method and the psychology of learning. Some teachers of the other subjects could be part-time lecturers, provided they were prepared to devote time to working out the inter-relation of different subjects with each other.

952. It goes without saying that the college would have to be within easy reach of field work facilities. This makes it essential that the local authorities in the chosen locality should be willing to play their part in the experiment by making supervisory time and other necessary facilities available for students.

953. If the college also had sufficient resources to undertake research in the social field, we think this would be a very great added advantage. The goodwill and active interest of a neighbouring university would also be of the greatest importance, indeed we would hope that more than one department would be prepared to play a part in the activities of such a staff college. We made a passing reference earlier to a forum for senior administrators. If our proposed institution were really to be a staff college we think it highly desirable that it should provide a common meeting ground for discussion between such administrators, members of other relevant professions, and university teachers in allied subjects. Some of the varied issues which will be involved in implementing, in England and Wales, some of the recommendations of the Report of the Royal Commission on the Law relating to Mental Illness and Mental Deficiency spring to mind, but there are many other matters urgently requiring joint discussion, inquiry and research. We ourselves have raised a number in this Report.

954. It will be apparent, from what we have said about the activities of the proposed college, that it would be designed to draw local government officials and others from all over the country. Some of its training activities would eventually be discontinued or contracted, as and when sufficient regional facilities became available under the National Council for Social Work Training.

955. We are well aware that complicated negotiations would be necessary to bring an institution of this kind into existence. We hope however that the proposals will meet with sufficient interest and goodwill for these obstacles to be surmounted and for the necessary financial help to be forthcoming. We have no doubt as to the valuable part it would play in the social services generally.

THE NEED FOR RESEARCH: FINANCIAL ASSISTANCE

956. We have referred throughout the Report to many points in our inquiry at which we found little or no information available. Sometimes the research required goes far beyond the bounds of social work but at the same time it is essential to the development of an effective social work service, for example into the personality development and social needs of those who are born deaf. We have also drawn attention to the lack of data on which to estimate in any precise way the percentage of persons in any given category who may need social work services. Within the field of social work we have been conscious of the need for analysis of the functions and activities of social workers ; of criteria for determining optimum and maximum case loads, and so forth. We also draw attention (paragraph 1080) to the need for more research and inquiry into the operation and effective

use of case conferences and co-ordinating committees. The results of this and other research and inquiry, as well as that which is already available, should also be incorporated into teaching material for students, whether at the training stage or in later more advanced courses.

957. A limited amount of research of this kind is already undertaken by the universities, sometimes financed by grants from trusts. Much more support is, however, needed if continuous research and inquiry is to be undertaken. Some studies can be so planned as to reinforce each other and to carry further the results of earlier inquiries ; others would be directed to newly identified need for further knowledge. We therefore **recommend** that legislation should be introduced to enable the appropriate government departments and local authorities to incur expense in conducting, or assisting other bodies to conduct, research of the kind to which we have referred.

PART IV

Chapter 10

LIAISON WITH WORKERS IN RELATED STATUTORY SERVICES: MAKING THE SERVICES KNOWN

958. We have emphasised throughout this Report the importance of co-operation between different types of worker in the social services, and of team-work and co-ordination of effort. In this chapter we discuss liaison with workers in related statutory services, and in the following one with voluntary organisations and voluntary workers.

959. Social workers trained in casework are comparatively new members of the team so that some authorities have little experience of how they fit in. It may appear to such authorities that there is not sufficient need to appoint a trained social worker, or that other types of worker, more especially the health visitor, can cover the ground. It has been said that local government, like nature, abhors a vacuum and if there is a job to be done someone will do it whether or not it is part of his particular function, or appropriate to his training. This is certainly true so far as social work is concerned. The needs in the health and welfare services are indeed so varied that many different types of worker have at different times tried, often with a measure of success, to provide some of the help required. We have noted this in relation to the functions of occupational therapists (paragraph 546). We come now to consider the social element in the work of other workers in related fields and in particular health visitors who, perhaps more than others, have filled the vacuum, especially in relation to families with young children.

Health visitors and home nurses

960. At various points in Chapter 3 reference was made to those services in which health visitors play a part in meeting social needs. Much of the evidence paid tribute to their work but some of it suggested that where social problems are complex there is a considerable variation in the extent and efficacy of their contribution. One of the field investigators, in discussing this point, noted that there was often no appropriate social worker to whom a difficult case could be referred and the health visitor felt obliged to take it on herself. We ourselves saw instances of this kind during visits and it is, in our view, partly for this reason that there has been a tendency to extend the duties of health visitors beyond their original functions at a time when the general shortage causes difficulty in providing a full health visiting service.

961. The value and importance of the work of health visitors is well recognised, notably in improving the health of mothers and young children and raising the standards of child care, in the follow up of the sick and chronic sick discharged from hospital, in promoting the health of the elderly, in the care of the tuberculous, and whenever special diets are

required or other aspects of medical treatment must be considered. Their work in these spheres inevitably brings them into contact with a variety of social problems. It is clearly desirable that their training should enable them, in the course of their normal duties, to recognise the signs of these, and that they should have a good understanding of the functions of other workers, so as to refer cases appropriately.

962. It is our belief that there are advantages in having two field workers trained in different professional disciplines, and we are firmly of the opinion that health visitors and social workers should provide a complementary service. We have noted in an earlier chapter that others have expressed a similar view.

963. The great asset of the health visitor in the social sphere is her knowledge of the treatment and prevention of disease and the promotion of health, the proper care of young children and the teaching of mother-craft. In her nursing training she works under the general supervision of a doctor and learns to observe significant factors from the medical point of view. As a health visitor she develops, by training and experience, her knowledge of the impact of these factors in the home and on the family from the social and psychological point of view. Many find this aspect of their work of particular fascination, as indeed it is. It is necessary that there should be some overlap of knowledge between health visitors and trained social workers if they are to provide a complementary service and co-operate with each other. An overlapping of function may occur where social workers are not available or are not fully trained. At present, when there are insufficient trained social workers to carry their appropriate share of the work in the health and welfare services, the division of territory is shadowy and a proper delimitation of functions has yet to be worked out. The implementation of our training proposals should help to clarify this situation. It should also enable health visitors and social workers to regard each other as essential members of the team, and not as rivals in the same sphere. This we regard as vitally important.

964. The Working Party on Health Visitors recommended that the functions of health visitors should primarily be health education and social advice. There have been many changes in the scope and need for health education since health visitors were first concerned with cleanliness, adequate feeding and infant mortality. Aspects of preventive mental health which were regarded as being only within the province of child guidance clinics thirty years ago are now matters of common knowledge, and a similar process is found in other fields. It is difficult to define the boundaries of health education and we shall not attempt to do so. To some extent all workers in the social services are concerned with healthy living and social adjustment, the housing manager and public health inspector as well as the health visitor and the social worker. The Working Party on Health Visitors defined social advice as including

> " Any social action taken to enable the client to follow the health advice given—usually direct practical advice on family management but often advice to turn to others when more help is needed. It must also include however advice on matters brought to notice that have superficially little or no bearing on the immediate question of personal and environmental health. It would be clearly wrong that an obvious difficulty should be ignored merely because a visitor was

not directly concerned. On the other hand social action is in general limited to advice to the client, referral of the case to another worker or a recommendation that a service should be provided."[1]

Social advice in this sense will be effective when it fits in with the client's own desires and capacities. In more complex situations it may fail if the deeper causes of the problem have not been ascertained. This requires "referral of the case to another worker" for social assessment, which is the function of the social worker as the first step in social casework.

965. The kind of situation where advice alone is unlikely to be effective was illustrated in one field study in an authority where health visitors had responsibilities for social welfare. The logbook kept by one recorded a 40 minute visit to a family with the following problems.

> (18) Tuberculosis contact visit. Diabetic mother, father disabled and on National Assistance, family problems. Contacts well. Daughter and husband are separated, two children in the care of the local authority. Another daughter will not keep her house or children in order. Two school children are bed wetters. Advised mother on best way to cope with each situation.

This brief sketch of inter-related family problems suggests that though the medical aspects are important, the significant factor may lie in disturbed personal and family relationships. It will therefore be of no avail to advise the mother before an assessment has been made of the situation as a whole, and of the extent to which each member of the family is likely to be able to respond to casework help in meeting their problems.

966. Some of the evidence which referred to the general availability of health visitors suggested that this was synonymous with a general acceptability, and concluded that only a worker with nursing training could deal with problems arising in the home. We do not think there is any independent evidence to support a contention made in such broad terms; certainly none has reached us. Nor is there evidence, so far as we are aware, to indicate that social workers are not equally acceptable in their proper sphere. The suggestion that a statutory or health function is necessary in order to gain access to a home is a similar misconception. The experience of social workers in being freely invited into homes was supported by the field studies and our own visits of observation.

967. It was also suggested by some witnesses that the health visitor was so regular a visitor to all families that she became the family confidante with an intimate knowledge of the life of the whole community. We do not think any worker would claim such encyclopaedic knowledge; nor do we think that health visitors would themselves agree that their visiting was so unselective as to embrace all the families in their district, regardless of whether their help was required. This would hardly be possible in view of their case loads, if for no other reason. In our view, overstatements of this kind tend to diminish a proper appreciation of the real functions and work of health visitors, and to exaggerate the idea that there is lack of co-operation between them and other workers.

968. We mentioned in paragraph 960 that there was often no social worker to whom health visitors could refer a difficult case. One example was seen in an area where a health visitor took our observer to see a mother recently

[1] An Inquiry into Health Visiting. H.M.S.O. 1956, paragraph 293.

discharged from a mental hospital. Since her return home the mother had been over-anxious about the house and children, both of which were spotless. She talked to the visitor incessantly for half an hour about the house, the relatives who had looked after it in her absence, the children, and her fears that she was not managing things well. The health visitor had arranged a home help and herself visited regularly and let the mother talk, but she was conscious of the need for guidance in trying to prevent relapse. An example of effective co-operation between a health visitor and a trained caseworker was given in one field study.

> (19) An old gentleman suffering from tuberculosis, whose married son was not prepared to have him home after hospital treatment because there were young children in the family. The almoner and health visitor discussed the situation, agreed on a plan, and on the voluntary and statutory organisations which each would approach. The old man was eventually discharged to a converted flatlet house for older people situated close to an old people's club. The tuberculosis care committee helped with furnishing, a meals service was arranged, and the National Assistance Board looked into the financial circumstances. The company of his contemporaries and the ease with which he could attend the club helped to lessen the loss of interest previously supplied by living with his son's family.

969. In paragraph 656 we referred to evidence, mainly from the medical and public health nursing organisations, which suggested that the role of a general purpose social worker was already filled by the health visitor or that she could, in combination with one or more types of officer, fulfil this function in the health and welfare services. In support of this view some of these witnesses referred to the Report of the Inquiry into Health Visiting which stated

> " In association with the general practitioner the health visitor will be concerned with a wider range of families than any other comparable worker. She will be in touch with the various family health and welfare teams. She has thus the opportunity to act as a common point of reference and a source of standard information, a common adviser on health teaching, a common factor in family welfare. In the ordinary course of her work, and without exceeding her competence, she could be in a real sense a general purpose family visitor."[1]

970. This 'general purpose family visitor' bears sufficient similarity to the 'general purpose social worker' in our terms of reference to have added to the confusion in the evidence regarding the functions of social workers and health visitors. So far as social workers are concerned we have said we hope the term will not be perpetuated. In the body of their report the Working Party on Health Visitors elaborated the 'general purpose family visitor' as follows

> " It would be foolish to suppose that the health visitor could be equally effective in all aspects of family welfare. We expect on the contrary that she will be really expert in only a few, mainly those where problems of health are dominant. It would be rash too to expect that all health visitors could adapt themselves to a wider role with equal ease. At the same time we are satisfied that the training of the health visitor could be so arranged that she would be better able to appreciate the problems that other workers face and the way in which they deal with them. She could thus be put in a position to observe the early signs of distress in fields in which she is not (and need not be) an expert, to consult the

[1] An Inquiry into Health Visiting. Summary of main conclusions and recommendations (x).

appropriate worker and to help in any measures that may be arranged. Where no such advice was available she could assess what first aid she could herself supply. She could thus have the opportunity to share in the work of a variety of family health and welfare teams that without her might have no common membership."[1]

971. We agree that the health visitor is an essential member of the team, a first line of defence in social action concerning the well-being of children, and one who should be among the first to recognise symptoms of neglect, malnutrition and ill-treatment in children of school age and under. If she is also the school nurse she has further opportunities with regard to school children. Equally she can appreciate signs of ill health or strain in the mother. In addition she will often be the person to whom a mother expresses doubts about the mental or physical development of a young child. She will know the homes where domestic standards are seriously below normal, or where elderly people living alone are beginning to fail; she will frequently be aware when sickness, ill health or disease is causing strain in a family. She can be a source of strength to the unmarried or deserted mother struggling, without the support of a husband, to care for a baby or young children alone. Where no young children, sickness or ill health, cause her to visit a family she is less likely to be aware of difficulties in regard to adolescents and young adults, disturbed marital or family relationships, financial or employment problems.

972. The extent to which health visitors will be associated with the two types of social worker we recommend will naturally vary. Our proposals for an officer with a general training in social work will strengthen the social work services and provide trained social workers able to co-operate with and complement the work of health visitors. The development of a working partnership between these two types of officer is extremely important in the interests of those for whom the services are provided. Perhaps the best examples of the combined effort required are seen in work with 'problem' families, or where both are concerned to help a family hold together in spite of illness or other calamity, and to prevent the children being received into care.

973. Social caseworkers with advanced qualifications could be available to individual health visitors (as well as to social workers) to advise on difficult cases. Help of this kind was obviously desirable in the first situation outlined in paragraph 968. A beginning has been made on these lines in some areas and we hope it will be encouraged elsewhere. There is scope for a close partnership with family caseworkers in much of the health visitor's own work with families.

974. Whatever the local arrangements, we think it would help if everyone concerned could agree that there was a point at which they did not know enough—social workers of medical and health matters, and health visitors about social casework. No single type of worker can provide a comprehensive service and the inter-relation of health, welfare and social needs makes it essential that no one should think they can. It would help, too, if everyone could agree there was a problem of co-operation and co-ordination to be discussed, thought about, and worked out. A marriage guidance counsellor should know enough to recognise a legal problem in a client's

[1] Ibid., paragraph 315.

marital difficulties but he refers it to a lawyer and does not try to solve it himself. Many social workers have extensive experience of, or some training in, nursing but they do not regard themselves as nurses and would seek the help or advice of a trained nurse in other than an elementary nursing situation. The same principle applies in health visiting, that is to say, both health visitors and social workers need to know enough to know when one competence ends and another begins.

975. In any event, neither the health visitor nor the social worker can claim to be the only worker with a contribution to make in the social aspects of the health and welfare services. The home nurse, for example, is equally well placed to recognise social needs. The increased turnover of hospital beds raises many problems of home care with which both nurse and social worker will be concerned. The home nurse is a familiar figure in her district and visits a wide range of families; she also is a trained observer who can recognise the need for social action.

The medical profession

976. In addition to being new in the local authority services, social work is new among the professions. On the whole, few doctors know what social workers can do, or the way in which they can contribute to medical treatment if personal or social factors prevent a patient from making the best use of such care. The consultant in a teaching or other large hospital usually knows, and understands, the functions of the almoner or psychiatric social worker. The medical officer of health, if he has such officers on his staff, will recognise their function in work with the mentally ill and disturbed or maladjusted children, and also in the social aspects of the after-care of the tuberculous and those with other illnesses. General practitioners have much less opportunity than either consultants or medical officers of health for co-operation with trained social workers. They may know of, and perhaps co-operate with, the almoner during hospital training, but the social aspects will as a rule only become significant, in the surgery or in the home, when it is their own patients who are sick and in need of help. Although more emphasis is now placed in the training of medical students on the importance of social factors in health and disease, the experience of the General Practice Teaching Unit in Edinburgh suggests that the young general practitioner may at first be overwhelmed by the magnitude of the social problems arising in his practice. As he recognises the value of taking these into account so he will look for someone able to assist in this field. Some general practitioners as we have seen, already find it convenient to refer social problems to a local health authority almoner, and generally speaking once these workers have proved they have a contribution to make general practitioners continue to use them. The processes used by doctor and social worker are to some extent comparable—relevant history taking and assessment of the problem, medical or social diagnosis, treatment and follow up.

977. Many medical problems have a social aspect. It was suggested to us by the medical organisations that all social problems have a medical aspect. We do not think this is invariably the case but we agree with these witnesses that it is essential for social workers to keep the medical aspects in mind, and to ensure, whenever a doctor is concerned, that he is kept informed of social action affecting his patients. There is, as a rule, good

co-operation between general practitioners and duly authorised officers because each has need of the other in dealing with mental illness. The same considerations apply in work with unmarried mothers and the workers concerned with these problems, and also in regard to the home help service. We were told more than once that where a good relationship had developed between this service and local general practitioners it was common practice for a doctor to ask for, or suggest, a particular home help for a particular household.

978. A similarly close relationship between doctors and social workers is essential in the care of the elderly, and with mentally and physically handicapped children and adults. So far as children are concerned, social workers should normally work closely with general practitioners, medical officers and health visitors. In adult life even if little more can be done by way of medical treatment there may yet be considerable room for better personal and social adjustment and there must still be close liaison with the medical side. Sometimes medical guidance will be required on prognosis, or on individual capacity for occupational or social activites. In some authorities occupational therapists look either to the medical officer of health or a general practitioner for such guidance. A similar working arrangement should apply to social workers in the health and welfare services.

979. We are sure it should never be assumed without inquiry that general practitioners are too busy to be kept in the picture, or to attend a case conference when the individual or family problems of one of their patients are to be discussed. Replies to the questionnaire occasionally recorded family doctors among those attending such meetings. The British Medical Association were anxious that this practice should be extended, but pointed out that case conferences could be a time-consuming element in a busy day. Certain preliminaries will therefore help, such as a brief note explaining the situation and asking the doctor if he would care to be present, and if not whether he has any comments to make, or a brief telephone conversation made at a convenient time with a similar purpose. We use the words brief and convenient advisedly. It has been put to us that social workers can learn from health visitors in both these respects. The latter with her nursing training is brief and to the point. The social worker, conscious of the importance of innumerable factors in a social or family situation, is sometimes inclined to give over-much detail and does not always appreciate the necessity of telephoning at a convenient time. If the doctor has been unable to attend, a note of the decisions taken (and a progress report from time to time), should always be sent. It might be argued that this all adds to the clerical work of officers already hard pressed, but, if team-work is to become a reality, keeping the other members of the team informed is an essential element, not least if they have originally referred the case.

980. Team-work is also an important element in liaison with the hospital service. Information on social matters affecting individual patients or their families is normally made available to the consultant or other doctor through the medium of the almoner or psychiatric social worker. There may be no necessity for continuing liaison in short-term hospital care but it will usually be required if attendance is prolonged, and especially with geriatric units. The increased turnover of hospital beds and the emphasis on domiciliary care is

shifting the focus in both psychiatric and medical social work from the hospital to the community. In ensuring continuity of social care, local authority social workers should keep both hospital consultant and general practitioner informed.

981. In all local authorities medical advice and guidance is available from the medical officer of health and his medical staff. The medical officer of health is responsible for all services under the National Health Service Acts; in a proportion of authorities he is also responsible for services under the National Assistance Act. The principle of consultation between field workers and medical officers is well established in the maternity and child welfare services; in social work it is usually close in the mental health and after-care services and, to a lesser extent, in the services for the blind. We should like to see it better developed generally, in particular in regard to the deaf, and in social and family problems arising from the care of severely handicapped children or adults. Liaison in planning for the handicapped child is discussed in relation to the education services in paragraphs 994–996. There is provision, in the schemes for the welfare services for the handicapped, for consultation with the medical officer of health if admission to the register is in doubt. There will be many other occasions when it will be desirable as, for example, when application is made for rehousing, in the care of the elderly, or when non-infective tuberculous patients might benefit from craft or other facilities provided by the welfare services. The importance of close co-operation in these matters between social workers and medical officers does not detract from what has been said above about co-operation with general practitioners. Both links are essential.

Children's departments

982. Many different types of worker share a concern to prevent the break-up of a family so long as this is consistent with the well-being of the children. Each approaches his task from a rather different point of view. The housing manager will usually agree with the Housing Management Sub-Committee's belief that "the preservation of a family as a unit, which is largely dependent on having a house to live in, is worth very great efforts for the sake of the children".[1] The Ministry of Health circular on the prevention of break-up of families[2] emphasised the importance of physical and mental health factors in family stability and urged local health authorities to develop their preventive work. The experience of many children's departments suggests that the removal of children from their families might have been avoided by preventive casework at an earlier stage.

983. In Chapter 12 we consider ways of improving co-ordination of effort. Here we are primarily concerned with liaison between social workers in health and welfare departments and child care officers. Part of the terms of reference of the Committee on Children and Young Persons (the Ingleby Committee) are relevant in this respect.[3] Whether or not there is any change

[1] *Unsatisfactory Tenants.* Sixth Report of the Housing Management Sub-Committee of the Central Housing Advisory Committee, H.M.S.O. 1955, paragraph 24.

[2] Ministry of Health Circular 27/54.

[3] The relevant part of the Committee's terms of reference are:

. . . to inquire into, and make recommendations on . . .

(*b*) whether local authorities responsible for child care under the Children Act, 1948, in England and Wales should, taking into account action by voluntary organisations and the responsibilities of existing statutory services, be given new powers and duties to prevent, or forestall the suffering of children through neglect in their own homes.

in statutory responsibilities following the recommendations of that Committee, the fact remains that the majority of families who show early signs of tension, deterioration of standards, or breakdown in family relationships should be known to the health and welfare services. Workers in these services will therefore have had an opportunity for preventive work or appropriate referral. The extent to which the right help is given will often be conclusive in determining whether the assistance of the children's department is required subsequently.

984. In the prevention of break-up of families the health and welfare services have certain recognised resources. In the health department these are the home help service when there is domestic need precipitated by a mother's illness, desertion, death, confinement or admission to hospital; the social caseworker (in authorities employing these workers) when certain more complex social or personal problems require intensive work; the health visitor in her own sphere and in noticing and reporting when things are beginning to go wrong; the mental welfare officer in families where there is mental instability or defect. The welfare department can provide temporary shelter and active measures to forestall eviction; it can also foster rehabilitation and assist resettlement in the community. But if there is a time limit on the length of stay in temporary accommodation this is more likely to precipitate, than to prevent, the taking of children into care. The lack of trained caseworkers in both health and welfare services must, in our view, have limited the extent to which either department has been able to assist with the more difficult problems.

985. The co-ordinated and wise use of the resources available will prevent a breakdown in many instances or shorten the time for which a family has to be separated. In some circumstances it may be more appropriate for a caseworker from the children's department to handle the situation from the beginning as, for example, when a family is already known to that department or when an application to receive a child or children into care has already been made. When there is family affection, and neglect rather than ill-treatment is the issue, the question of which department should be responsible may be most effectively decided by joint discussion. Social workers in the health department will usually be concerned with the unmarried mother, except when she applies to the children's department to take the child into care, or wishes to place him for adoption, or herself finds a foster home which makes him a protected child under the Children Act, 1958. Unmarried mothers and their children and certain families in temporary accommodation may call for joint effort.

986. In all matters involving the care of children where there is a risk of the family breaking up there should be a long-term or short-term plan, and not simply the handing over of responsibility by one department to another. There must be a study of the situation, assessment of the need and an agreed plan, which can be amended in the light of developments, as to how the need is to be met and the function of each worker. The development of liaison between child care officers and the home help service, of which examples have been noted, is one example of the fruitful co-operation we have in mind. In every case the needs of the situation, rather than departmental boundaries or jealousies, should be the determining factor in defining the responsibilities of individual workers.

Housing departments

987. It is thought that nearly a quarter of the population now live in local authority houses; thus many clients of social workers in the health and welfare services either are, or wish to be, council tenants. Co-operation between housing managers and their staff, and the social workers in these services is therefore an important element in a complete service. It may sometimes require fostering between different authorities in county areas. Attention is often focused in liaison with housing departments on the 'problem' family and on families who for one reason or another lose their homes and are admitted to temporary accommodation. But good co-operation between housing, health, and welfare departments is also an element in the care of the elderly, the unmarried mother and the tuberculous, in the welfare services for the handicapped and whenever an application for rehousing requires the support of the medical officer of health.

988. One of the effects of the new two-generation towns and large peripheral housing estates is the loosening of family ties. This is seen particularly when elderly people are left behind as a result of these miniature mass migrations. Several recent studies have drawn attention to the resulting fragmentation of family resources, and the weakening of kinship bonds, which accentuate the loneliness of the old. The problems are well known. They include the elderly person struggling to live and maintain independence in a house too big since the family grew up and left home, or living at the top of old property where water and coal have to be carried upstairs and communal sanitation must be shared. Apart from housing difficulties there is often increasing frailty or ill health, inability to manage shopping and domestic duties, and the slow deterioration which accompanies malnutrition. If the family is living nearby and is in touch, help from local authority or voluntary services is less frequently required; in suitable cases the housing authority may be able to arrange ground floor accommodation, or a transfer to a flatlet or grouped dwelling. A housing association or other voluntary organisation may offer comparable provision. The old person living alone and not in touch with family or relatives places a greater responsibility on the local authority, and a network of services, including the voluntary services, may often be required to ensure adequate care. The rent collector in council property is often the first to see the early signs of deterioration, and a regular exchange of information with the appropriate field worker will help to ensure that the right help is available in time. We do not know if housing managers or their staff are generally members of local old people's welfare committees—they do not appear to be particularly well represented on the co-ordinating committees for the care of children—but their regular contact with a proportion of the elderly population should be taken into account, particularly in areas where there are active slum clearance schemes.

989. The giving up of a tenancy on admission to residential care or on long term admission to hospital is frequently a painful decision for an elderly person. If it is to be made as easy as circumstances permit, the housing department officer and the welfare officer must work closely together whenever a council tenancy is involved. The welfare officer's responsibility for protection of property, already noted (paragraphs 495 and 662) will sometimes help the transition from the elderly person's point of view.

990. Arrangements for structural adaptations to the homes of handicapped persons are characteristic of co-operation between some housing authorities and the welfare services for the handicapped. These alterations often have dramatic results in increasing the mobility of a handicapped or homebound person, or in enabling a disabled housewife to carry on with her normal domestic duties. Suitable living accommodation is essential for paraplegics and other severely handicapped persons if they are to retain the maximum possible independence. It is often a decisive factor in obtaining and keeping employment, in leading an adequate social life, or in making use of the facilities provided by the welfare services. There will be other requirements—for example for a home help—which emphasise the need for continuing co-operation. There are comparable considerations in the rehousing of the tuberculous, where the importance of medical and health factors has usually ensured a well established relationship.

991. The value of working closely together on family problems is obvious. The evidence of the Society of Housing Managers pointed out that even the most self-reliant families are sometimes faced with difficulties with which they may be unable to deal without help. The housing manager, in becoming aware of impending trouble at an early stage, can bring together the family and the social worker able to assist. This is of particular importance with regard to rent arrears. In such cases co-ordinated action by housing, health and welfare departments is greatly facilitated by direct contact between field workers. Where arrangements of this kind have been tried out, experience shows that both rent arrears and the demand for temporary accommodation can be reduced.

992. In *Unsatisfactory Tenants* the problems presented by the more difficult families were surveyed and suggestions made for the prevention of eviction by early action, exchange or transfer to a cheaper house, operation of differential rent schemes and the use of older or intermediate property for families who were either in danger of losing their houses or, having lost them, were being helped to become acceptable tenants once more. We particularly welcome the recommendation that housing authorities should regard unavoidable eviction as a stage in treatment, and that the ultimate aim should always be to re-establish the family in a home of its own. Whether or not special rehabilitation facilities are available in intermediate accommodation provided by housing authorities, in temporary accommodation or in special rehabilitation units, the active help and co-operation of social workers in the health and welfare services should always be available.

993. A similar positive attitude on the part of officers and committee members of the departments concerned is needed for unmarried and unsupported mothers with one or more children. The particular difficulties of this group have been noted throughout this Report. One of the most acute is in obtaining a home of their own. We cannot do better than quote *Unsatisfactory Tenants* on this point since it represents our own view.

> " . . . Yet it would appear at least as desirable that children deprived of a father should be given the advantage of a home background as children with both parents . . . Not all these mothers would be competent to set up and manage a home, and in some cases it might not be right to encourage it. As the County Councils Association point out, however, these women are ' frequently devoted mothers from whom it would be most undesirable to separate their children ', and yet if no individual homes can be found for them, there is a grave risk that

this will happen. . . . We should like to support the suggestion of the County Councils Association that in the interests of the children housing authorities should, in appropriate cases, offer such families some of their lower rented houses."[1]

Education departments

994. The responsibilities of education departments, and the close link between school and other health services, are another facet of team-work and liaison, in this instance between education, health and social workers. Teachers, school doctors and nurses, and in particular education welfare officers, are in touch with a large proportion of the child population in their areas. The evidence offered to us by the Education Welfare Officers' National Association particularly stressed this point. All these officers have, therefore, excellent day-to-day opportunities of seeing when help is needed, either from one of themselves or from other workers. The fact that a child's behaviour at school is affected by the home situation is now generally recognised. Like rent arrears, persistent tiredness, apathy or behaviour difficulties at school, truancy or constant absences to be at home are danger signals in the stability of family life. The importance of co-operation by all concerned in assessing the situation, and in seeking to apply remedies, need hardly be emphasised.

995. Ascertainment of the educational capacity of mentally or physically handicapped children brings the education services into the picture at an early age—in some instances this may be at 2 years. Early decisions may have to be taken about future schooling at a time when the medical prognosis is still uncertain. It is often difficult for parents to reach these decisions or to accept the course of action suggested. They may have to try to balance the advantages of a residential special school against the loss of home life, or of special teaching in the home against the claims of other normal children. Social workers in the health and welfare services should be available to assist education departments in making educational plans by offering an assessment of the family situation.

996. They can also keep in touch with the home while the child is away in hospital or residential special school, and during school holidays. There may be difficulties during a temporary return home—the child may react to the change in routine, for example, or the other children in the family may resent the time and attention devoted to him. Social workers, in co-operation with the education department, can help to anticipate some of these difficulties and provide whatever help may be indicated. Casework can help to strengthen home ties and affection, and lessen the family strain.

997. The transition from special school to adult life at school leaving age is often a difficult period for handicapped young people. The change in environment has to be faced at a time when plans must be made for vocational training and eventual employment, and adjustments are required in living at home and to life in the community. The youth employment service of the education authority, or of the Ministry of Labour and National Service, provides vocational guidance and help in finding suitable employment, the education department is also responsible for further full-time or part-time education. The Committee on the Rehabilitation, Training and Resettlement of Disabled Persons noted that youth employment officers

[1] *Unsatisfactory Tenants*, paragraph 81.

had an important role in helping all school leavers, and a vital one in placing and following up disabled young persons so that they did not drift into unsatisfactory occupations.[1] Co-operation between these officers and social workers should always be close. If suitable employment cannot be found, the welfare services for the handicapped or the mental health service can provide occupation or social activities and also help in overcoming the effects of the disability to such extent as may be possible. In theory a number of services are designed to cover this critical period. We are not convinced that they always function according to a co-ordinated plan, particularly if the disability is severe. Some authorities arrange case conferences at school leaving age where all concerned can discuss what may be required. A few of these also consider arrangements for the educationally sub-normal school leaver not subject to supervision under the Mental Deficiency Acts. The Piercy Committee received some evidence deploring the gap between the normal school leaving age of 15 and the minimum age of 16 for vocational training under the Disabled Persons Employment Act, 1944.[2] The Committee pointed out that there was no gap so far as special school pupils were concerned since attendance at these schools was compulsory up to 16 years of age, but they recommended that the normal school leaving age should become the minimum for vocational training and industrial rehabilitation.[3] It is our impression that the gap is not so much in the services available but in ensuring that they are provided, known and used.

998. At this stage of his career the young handicapped person, poised between adolescence and adult life, is the partial concern of several statutory services. It can easily be overlooked that he may personally need help with all the far-reaching decisions that have to be taken. The social worker in either health or welfare services can give this support in co-operation with the youth employment officer and others concerned. The case conferences referred to above can also be useful in this respect and we should like to see them held whenever appropriate. Similarly we should like to see social workers in the welfare services under the National Assistance Act in touch with education department officers before these young people—and especially the deaf—leave school.

999. The staff of child guidance clinics are familiar with families where psychiatric disturbance or maladjustment has been diagnosed. The Committee on Maladjusted Children,[4] in reviewing the facilities for the after-care of maladjusted children, recommended that local education authorities should provide a service of personal help for children still at school and up to the age of 18, adding that if necessary the law should be amended to enable this to be done. In that Committee's view, psychiatric social workers on the staff of child guidance clinics were often the most suitable workers to keep in touch with these children, but it was recognised that they did not always have the necessary time. The Committee suggested that other social workers, teachers, health visitors or officers of a suitable voluntary organisation

[1] Cmd. 9883, paragraph 251.

[2] Ibid., paragraph 257.

[3] The Disabled Persons (Employment) Act, 1958, has since reduced the minimum to the normal school leaving age, i.e. 15 or 16 according to circumstances.

[4] H.M.S.O. 1955, page 89 (*a*) and (*b*) (1).

might be used in this way. We think that as health and welfare departments develop social work services staffed by trained social workers this need could largely be met by these departments.

1000. The help of the education department should always be sought if sick or handicapped people want to devote time to study or to further education, either at home or at classes provided by the authority. It may sometimes be possible by careful planning for even a severely handicapped person to attend a further education class. The help which can be given by craft instructors should also be remembered.

The Ministry of Labour and National Service

1001. Lack of work, or unsuitable employment, is at the root of many social problems ; some will be insoluble if the fundamental need for work cannot be satisfied. Co-operation between social workers in the health and welfare services, officers of the youth employment service and the disablement resettlement officers of the Ministry of Labour and National Service, is often essential in the after-care of the handicapped and the sick, and whenever unemployment is an element in family problems. The importance of co-operation with the youth employment officer has been referred to (paragraph 997). It is equally important with disablement resettlement officers.

1002. The functions of disablement resettlement officers are to assist disabled persons, who are capable of (or likely to become capable of) remunerative employment, to find suitable work, taking into account medical advice on suitability of employment and the disabled person's previous experience and qualifications. They are responsible for following up first placements to see whether these are satisfactory and keep in touch with a disabled person so long as this is required. The Piercy Committee received some evidence suggesting that in view of the special difficulties of the disabled, and the importance of medical considerations, this work might be more suitably undertaken by trained social workers. The Committee took the view that although there was a social element in much of the work of disablement resettlement officers their main function lay in the industrial sphere. They considered, furthermore, that the absence of supporting social services had frequently led disablement resettlement officers to undertake work more appropriate to social workers.[1] This is an opinion which we share. In some instances it may have been due to the absence of a hospital almoner, but a more cogent reason is often the lack of trained social workers in the health and welfare services. Our proposals for officers with a general training in social work, and for a more widespread use of caseworkers with advanced qualifications should go a long way towards building up these supporting services.

1003. Certain groups of handicapped people have special difficulty in obtaining and keeping employment because of the nature of their disability—paraplegics, for example, and others confined to wheelchairs, epileptics and spastics, the mentally disordered, the tuberculous and those with certain progressive diseases. Co-operation between the officers of the local authority, the Ministry of Labour and National Service, and voluntary organisations concerned with specific disabilities, is as a rule, well established. The Piercy Committee, in reviewing the general facilities for rehabilitation, training and

[1] Cmd. 9883, paragraphs 183–186.

resettlement, recommended that hostels should be provided for the tuberculous whose home circumstances were unfavourable, or who found difficulty in obtaining lodgings near their work.[1]

1004. The Committee also recommended that local authorities should experiment with similar provision for convalescent patients discharged from mental hospitals either while undergoing training or on first starting work. They reached the conclusion that certain groups of the mentally disordered required particular help in settling into employment.[2] These groups corresponded broadly to those which the Royal Commission on the Law relating to Mental Illness and Mental Deficiency recommended for after-care by the local authority, that is to say, the mentally ill on discharge from hospital treatment or convalescence who need help at home as well as in obtaining employment, those with a residual disability requiring psychiatric supervision or after-care in the community, and the high and middle grade employable defectives in both groups. There are indeed likely to be considerable difficulties in the resettlement of some of these individuals, and close co-operation between disablement resettlement officers and the community care services will be essential. We see a parallel with the tuberculosis service where the importance of co-operation between chest clinic staff and disablement resettlement officers is well recognised. The latter look to the chest physician for guidance on suitable employment, and to the almoner (where there is one) for casework support and any practical assistance required before and during the critical period of a first return to work.

1005. The Piercy Committee further distinguished a category of persons who are unable to settle down and whose behaviour difficulties suggested that they might also be mentally ill.[3] This is the group, some of whom we have noted (paragraph 598) as drifting between reception centres, lodging houses and Part III accommodation. Generally, it appears to us that the success of any attempts at resettlement and employment will depend on how far personality difficulties and consequential social problems can be relieved. We agree with the Piercy Committee that all who come in contact with such men and women should know from the department concerned—usually the health department—how proper psychiatric advice can be obtained. Disablement resettlement officers in particular should also be able to call on psychiatric social workers or mental welfare officers when appropriate.

1006. Persons suffering from epilepsy may be subjected to considerable strain in finding and keeping employment. Social workers in the community care, after-care, or welfare services for the handicapped should co-operate with disablement resettlement officers and other workers concerned, and undertake such casework as may be required. Similar co-operation will often be needed for other severely handicapped persons, particularly paraplegics and spastics and those with progressive physical or nervous disorders.

1007. We referred in paragraph 270, to the special placement service for the blind, and to the recommendation of the Piercy Committee that the Ministry of Labour and National Service should assume responsibility for these arrangements. Co-operation between placement officers, whether employed by voluntary organisations or local authorities, and other workers

[1] Ibid., paragraph 282.
[2] Ibid., paragraphs 293–297. This has been brought to the attention of local authorities in England and Wales by Ministry of Health Circular 16/58.
[3] Ibid., paragraph 290.

with the blind should always be close. The voluntary organisations for the deaf regard the finding of employment as one of their major contributions to the general welfare of deaf people. It is too early to judge whether local authority officers will be called upon to play a part in this connection, but clearly they should work closely with both voluntary organisation staff and disablement resettlement officers.

The probation service

1008. What we have said (paragraph 986) regarding liaison between local authority departments in the care of children where there is a risk of family break-up, applies also to social problems with which probation officers and social workers in the health and welfare services may be concerned. These may arise in relation to children and young people but a similar assessment of the situation, and agreement on the part to be played by each type of worker, is desirable with adults or in family problems where there is some degree of mental disorder or instability.

The welfare service of the Ministry of Pensions and National Insurance: disabled ex-service men and women

1009. Special facilities are available for the rehabilitation and resettlement of disabled ex-service men and women, and a welfare service is provided by the Ministry of Pensions and National Insurance. This includes a craft work service and help by a welfare officer with personal problems.

1010. Disabled war pensioners are eligible for registration as handicapped persons under the National Assistance Act. We have no means of knowing how many have either been registered, or make use of the facilities available, but co-operation between welfare officers in both central and local government services is very desirable in order to ensure that ex-service men and women are aware of the local authority services, and are encouraged to use them appropriately.

The National Assistance Board

1011. The figures published annually by the National Assistance Board show the number of weekly allowances current at the end of the year. These provide a striking illustration of the inter-relationship between this statutory service and the health and welfare services.

1012. In December, 1957, 1,200,000 of those receiving allowances (72 per cent), as well as 90,000 who were receiving non-contributory pensions though not assistance allowances, were over pensionable age. These elderly people, many of whom are also blind or otherwise handicapped, are visited periodically by the Board's officers. Some are in hospitals, nursing homes, or residential care provided by local authorities or voluntary organisations. Others are in lodgings, boarding houses or privately run homes. A number live with their families or with relations able to care for them, but many are married couples or single persons living alone. A high proportion of all these older people must also be known to officers in one or more of the local authority services. We received evidence of close liaison with National Assistance Board officers in many areas, and are glad to record this since it is an essential element in the domiciliary care of the elderly. It was in fact pointed out to us that the older people who often gave most cause for concern were those who lived alone and, having sufficient pension or

other private means, did not require assistance from the Board. They thus lacked the safeguard of a periodic visit.

1013. Co-operation between the Board's officers and social workers in the health and welfare services should provide a two-way flow of information, not only in relation to the elderly, though it is particularly important in that context. Some older people in lodgings, boarding houses and private homes, for example, may be unaware of statutory or voluntary services which could assist with a variety of problems or help to keep them in touch with the community. Families or relatives caring for an elderly person may also need help from a social worker if they are to continue to meet these responsibilities. In 1954 the National Assistance Board carried out a review of older people over the age of 80 living alone. This provided welcome evidence that there has been no general decline in the sense of responsibility of the younger generation for their older relatives. In fact a positive growth of concern and of neighbourly and community interest was noted in some areas. Clearly everything should be done to foster this healthy development, and to expand those services which can assist, in co-operation with the Board's own officers.

1014. Inevitably these officers meet difficult situations, affecting older people and other clients, in which a trained social worker could be of assistance. As with the disablement resettlement officers, it seems possible that the absence of supporting services in health or welfare departments limits the help which can be given. Families with rent arrears receiving rent allowances from the Board are another case in point. The practice, advocated by the Housing Management Sub-Committee of the Central Housing Advisory Committee,[1] of local authority housing officers notifying default to the Board at an early stage can often prevent ultimate eviction, especially if a concerted plan is made which includes either the welfare officer under the National Assistance Act or the social worker in the health department concerned with families. Whenever there is a risk in such circumstances of eviction, or of family disruption, we hope that co-operation on these lines will become an accepted part of social action by health and welfare departments. We were glad to find, in this connection, that National Assistance Board officers were amongst the most constant attenders at co-ordinating committees and case conferences on the care of children.

1015. Seven per cent of those receiving national assistance allowances in 1957 were women with young children, either widows, unmarried mothers or married women separated from their husbands. The difficulties of the two latter groups have been noted throughout this Report. Here again a high proportion must be, or should be, known to workers in one or more of the health and welfare services. Similarly with the blind and those suffering from respiratory tuberculosis (who formed 3 per cent and 1 per cent respectively of those receiving allowances). The registration figures for the blind indicate that a high proportion of new registrations come through the National Assistance Board, and confirm our own view of the valuable work of the Board's officers in drawing attention to the need for other services. Close co-operation is usual in this service and in the care of the tuberculous. It may sometimes be less close from the social work aspect with those incapacitated for work by sickness or other disability.

[1] *Unsatisfactory Tenants*, paragraph 48.

1016. The National Assistance Board has special responsibilities for persons without a settled way of life. We believe that trained social workers either in the mental health or the welfare services could assist some of the unsettled people mentioned elsewhere in this Report who sometimes use the reception and other centres provided by the National Assistance Board. Such help may be especially needed by persons in these centres who have been discharged from mental hospitals or who appear mentally unstable. Where a reception centre is provided by a local authority on behalf of the Board, the services of health and welfare department social workers should be freely available to reception centre staff.

1017. The National Assistance Board's officers visit a number of people, mainly elderly, who discourage callers and may even be actively disagreeable —the group sometimes described as 'unvisitable'. Sometimes it appears that little can be done in the early stages except for someone to keep in touch, a burden which may fall on the National Assistance Board because of the responsibility for periodic visits. But we think it likely that a skilled social worker might sometimes be able to make a helpful relationship with some of these unhappy and withdrawn people, some of whom eventually reach the point when compulsory removal under Section 47 of the National Assistance Act becomes the only solution. There is as a rule good liaison between local authority and National Assistance Board officers, and as more trained social workers become available to the local authority they should increasingly be used in these difficult cases.

Making the Services Known

1018. Liaison may be defined as co-ordination between allies, a definition particularly appropriate to meeting human needs. In the present context it implies an interchange of information for the benefit of those concerned and concerted action when this is required. Services which meet individual and family needs should be known to those requiring them and to the general public, as well as to workers in related fields. This is not always easy to achieve except when the need is apparent, or is brought to the notice of the appropriate service by a crisis, as when a family becomes homeless. It is more difficult with those who require a service but do not know how it can be obtained; with the elderly living alone, for example, or the homebound, or if an individual or family is unwilling, or unable, to admit the need for help. The right of people to live according to their own way of life within the limits of the law must always be respected, even though this may involve, particularly for the very young and the elderly, a risk of the kind of tragedy which is sometimes reported in the press. We have said that the client should be free to accept the service offered or to refuse it, and we have no intention of recommending measures which will interfere arbitrarily with other people's lives. Moreover, we wish to see measures which strengthen rather than weaken the community sense of individual and neighbourly responsibility. We think, nevertheless, that insufficient attention is sometimes paid to making services known locally, and also to establishing ways by which people in need of the health and welfare services can be discovered.

Information services and publicity

1019. Our attention has been drawn in this connection to the difficulty many people have in distinguishing between services provided under permissive

powers and those which are a statutory duty, especially as between one authority and another. We were told, for example, of a severely handicapped man formerly living in a county borough with well developed services for the handicapped who complained bitterly on moving into the adjacent county area, where there were no similar services. The same point was made about convalescence and recuperative holidays under the National Health Service Acts. In heavily populated areas it is possible for a hospital to recommend convalescence for two patients living in roughly the same district, but under two separate local authorities, only one of which will be in a position to help with the cost. A voluntary organisation wishing to arrange for 'neglectful' mothers to go to a recuperative or retraining centre may encounter the same difficulties. The decision to provide services under permissive powers is, of course, a matter for the local authority, but it is desirable that the position in each local authority area should be made clear.

1020. During the war, people automatically went to the Town Hall after a heavy raid whether or not the service they required was available there. In some areas it was necessary to concentrate all the relevant services in one building for this reason, and to prevent fruitless journeys. In normal conditions there are good reasons for decentralisation but they reinforce the necessity for a good information service and of good publicity at centres to which people are most likely to go. The volume of work reaching information services and citizens' advice bureaux during the war, and since, shows that many people can make good use of this kind of help and, given the relevant facts, are able to deal with their own particular problems, or make use of other services. Others do not have this capacity and may need individual help to make use of services which they may require.

1021. We asked in the questionnaire about information and publicity, and if there was a focal point to which inquiries were normally made. Replies indicated that about 95 per cent of authorities make their services known by printed or stencilled material issued either to the general public or with a restricted distribution (for example to general practitioners); by talks to local groups or meetings, or by articles or publicity in the local press. The least used method appeared to be publicity for the general public. We saw some examples of publicity material which were attractive, simply written and informative. Others consisted of pages of closely written print from which someone unaware of the general pattern of local government services might well find it difficult to extract information. Very few offered general help or advice, or said where this could be obtained. As a rule greater publicity was given to the health services than to the welfare services, which were noticeably less well publicised, except in those authorities which published information on the services for the elderly, and less frequently, for the general classes of handicapped persons.

1022. Publicity material for general use, and for groups with special needs, is more effective if it is designed from the consumer point of view than if it is set out alphabetically under legislation or specific local authority departments. We saw one excellent leaflet for old people which started with information about avoiding accidents in the home and simple advice on nutrition, and then went on to deal with specific points about wireless and dog licences, spectacles and financial matters—all likely to be of immediate interest to an elderly person. Only towards the end was there a reference

to residential care. We also saw one for expectant mothers which dealt first with the question of who could look after the family and the home during the confinement, again the query which would probably be uppermost.

1023. Material with a restricted distribution serves a different purpose from a general handbook or leaflets and requires a rather different approach. Some of the bulletins to general practitioners, which were attached to the questionnaire replies, were admirable and concise digests of information on medical and health matters but we saw only one which offered help with social problems which the general practitioner might find were adversely affecting the response of his patients to medical treatment. We suggest that when a local health authority is prepared to offer a casework service this might be made known to general practitioners in this way. We are not aware of any publicity designed for workers in other statutory or voluntary services comparable to that for general practitioners. There would be considerable scope for it both as a way of publicising a casework service and as a means of promoting co-operation and facilitating contacts between field workers.

1024. Replies regarding focal points for inquiries showed that authorities with information centres, public inquiry desks or citizens' advice bureaux realised the importance of these services, and of having experienced officers to deal with inquirers. One authority noted that it was not the practice to employ junior staff for this purpose. On the other hand quite a number saw no need for special arrangements. Others considered that the area or district welfare officer was himself a focal point for many public inquiries, especially in country districts, or that district or divisional offices served this purpose.

1025. The extent to which a service is known will often reflect its local prestige. If local services are truly local and the officers concerned are familiar figures in the neighbourhood there will be less need for extensive publicity than if there is no local office and staff are not allocated to specific areas. The area or district welfare officer has been mentioned ; home nurses, health visitors and education welfare officers are also usually well known in their districts. We received a good deal of evidence that these officers all played a part in publicising the services, and in hearing of specific needs.

1026. Good information services have become an essential feature of modern life and should be an integral part of the whole range of social services provided by local authorities. A well-planned information service would include publicity suitably designed for the purpose (including the use of visual aids), a central information bureau—which might be a public inquiry desk or a citizens' advice bureau ; local points of inquiry whenever possible, and field workers well known in their districts. Both central and local arrangements are required. Some people will not seek help if it involves a journey to an unknown office, while others will prefer to avoid the risk of their affairs becoming known locally.

Identifying people in need of help

1027. Local publicity arrangements also help to focus attention on the purpose of the services. Individual citizens need to know what to do if they come up against an obvious need, or see that something is wrong. Much of this is simply good neighbourliness. There is a very great difference in

seeing that help is wanted and knowing a service exists to meet it, and what is commonly described as 'snooping'. The milkman or the postman may see that an elderly person's milk bottles or letters remain uncollected. Someone knows of a homebound invalid who cannot get out to church or to the pictures. A family notices that the old lady next door is having increasing difficulty in doing her shopping, or her husband in keeping the garden trim. In many instances the milkman or postman will ask a neighbour to knock at the door and offer help, or the neighbours will do this themselves. If the need is more pressing they should know that a particular service or officer in the locality can help, if the person concerned agrees, and should have easy means of making contact with the service. Generally we think this preferable to the system of simply drawing the local authority's attention, by postcard or other means, to someone who does not know this action has been taken. Generally, too, we think it inadvisable to draw public attention by a window card or other system to the fact that someone is living alone.

1028. It becomes more difficult when the offer of help will not be welcomed, with the mentally disturbed for example, or an old person clinging to independence, or in the home where a child appears to be neglected or ill-treated. At some point good neighbourliness shades into community responsibility, and there should be a generally recognised way in each locality by which those responsible can be told that action may be needed. The mental welfare officer and the welfare officer know the limit of their functions if their help is unacceptable. The local authority knows when action must be taken in the interests of an individual or society, but too often press reports seem to show that arrangements for safeguarding the well-being of children or the elderly have not been used effectively.

Prevention

1029. In order to interpret the danger signals before a situation has deteriorated beyond repair, or irreparable harm has been done, an effective visiting and reporting service is required. This implies more than an obligation to be well-informed about other services and to have developed a good liaison with their workers, though both are important. It implies a sensitivity to other people's reactions and an awareness of the implications of what is seen and said (or not said) though it may have no direct bearing on the matter in hand. The Working Party on Health Visitors no doubt had this in mind when they said "It would be clearly wrong that an obvious difficulty should be ignored merely because a visitor was not generally concerned".[1] The implied but unexpressed difficulty is often even more significant in relation to future crises. Some of the incipient signs of trouble may be only the slight, but consistent, accumulation of rent arrears in a family which has always paid its way; the child intermittently kept home from school for no apparent reason, or beginning to show signs of neglect; a hospital in-patient who tries to avoid discharge; or an inexplicable change in attitude to, or growing suspicion of, a hitherto welcome visitor (a home help, or a voluntary visitor, for example) which may indicate gradual withdrawal from the community. Such signs may come to the notice of workers (including voluntary workers) in the related fields referred to in this chapter and throughout the Report, in the same way as the first signs of delinquency may be recognised by a social worker in the health and welfare services.

[1] An Inquiry into Health Visiting, paragraph 293.

1030. It is at this point, when there may be insufficient justification for intervention, that the information must not be overlooked or its significance missed. There should be a recognised procedure for this. It is not enough that someone should be thought to be watching the situation in the course of their ordinary duties. There should be regular discussion between the worker, whoever he may be, and a trained caseworker. Records should be so kept that at these discussions the situation can be evaluated over a period of time, significant factors or developments identified, and the most promising method of approach assessed. Later it may become necessary to consult other workers, perhaps to pool the information available at a case conference, and to decide on a course of action. But the early procedure is essential if the service likely to have the ultimate responsibility is to be on the alert and if real preventive work is to be done. We do not think departmental boundaries should be a major consideration in these arrangements as there must be sufficient flexibility to meet a variety of situations. The worker who keeps in touch may be the one originally concerned, or another may be found more appropriate. The caseworker may or may not be in the same department as this worker. The criterion should always be whichever working partnership is best in the individual circumstances. The responsibilities of local authorities for preventing human suffering are clear, but the most effective ways of ensuring this are still being worked out. Making the services known is one way, but the authority must also satisfy itself that everything possible has been done to ensure the recognition of individual needs so that the right help is given at the right time.

Chapter 11

THE CONTRIBUTION OF VOLUNTARY ORGANISATIONS AND VOLUNTARY WORKERS

1031. In Chapter 1 we traced the part played by voluntary organisations and voluntary workers in the services within our terms of reference; without exception each owes its origin to voluntary effort, often religious in its inspiration. The range, variety and continued vitality of voluntary service is impressive and encouraging: impressive in its range and variety because of the compassion and concern for others which it shows; encouraging in its continued vitality because it confirms that the voluntary spirit is still actively fulfilling its traditional role of pioneering new services and complementing the statutory provision.

1032. The term voluntary effort covers a multitude of activities, organised and unorganised. The good neighbour is a voluntary worker though she may never have thought of herself in that way. Fortunately there are always people who combine a readiness to help others with a sense of community responsibility; they are often a mainstay of their immediate neighbourhood. These are the people who will let the statutory officer know when he is needed or may lend a hand in helping out a statutory service, for instance if a home help is unavoidably absent. However complete the statutory services may become, and however active the voluntary organisations, there will always be room and need for the good neighbour.

1033. The members of local authority health and welfare committees are themselves voluntary workers. Witnesses have told us, and we have seen for ourselves, that officers of these committees also undertake an immense amount of voluntary work in addition to their statutory duties, sometimes helping to promote a voluntary organisation or serving on it in an honorary capacity. In their own time they continue a service to the public which by its nature can never fit neatly into prescribed hours of work.

1034. A clear distinction is necessary between voluntary organisations and voluntary workers. By a voluntary organisation we mean one which decides and controls its own policy; this, of course, by no means rules out consultation or co-operation with statutory bodies. A voluntary organisation may employ paid staff, it may rely wholly on unpaid workers, or it may use both. The voluntary worker is unpaid, he is an amateur in the literal and best sense of the term even if, as sometimes happens, he is professionally trained. He may work for a voluntary organisation or for a local authority, as in the children's care organisation of the London County Council. Since 1948 there has been a ferment of experiment in the use of voluntary workers by health and welfare departments, especially in the care of the elderly and in the new services for the handicapped.

The present picture

1035. The evidence, the questionnaire returns, our own observations and the reports on the field studies make it abundantly clear that voluntary effort is an integral part of the health and welfare services. Nearly all local authorities use voluntary homes for the elderly, for unmarried mothers and the handicapped. With few exceptions they co-operate with local old people's welfare committees, with moral welfare associations, and with organisations for the blind, deaf and physically handicapped, in many cases by formal agency agreement. There is more limited use of some voluntary organisations, partly because the resources of these organisations are limited. Marriage guidance councils and family casework agencies, for example, are not universal, and there are at present only 11 Family Service Units in England and Wales (all of which are used by the relevant local authorities). The percentage of local authorities (by regions) co-operating with various types of voluntary organisation at 1st May, 1956 is shown in Table 56. There is no recognisable pattern according to type of area or distribution of population, but the figures give some indication of the diversity of practice. The greatest use, as might be expected, was in providing for the blind (87 per cent); the deaf (85 per cent); the elderly (83 per cent) and the unmarried mother (70 per cent). The figures for tuberculosis aftercare (31 per cent), mental health and deficiency (27 per cent), convalescence and recuperative centres (13 per cent), and organisations providing casework services for families (4 per cent) are low in relation to the importance of these or equivalent local authority services. It seems clear in relation to the services within our terms of reference, that although both the National Health Service and National Assistance Acts empower local authorities to use voluntary organisations, much greater use is at present being made of those providing services broadly within the scope of the National Assistance Act. The information in the replies regarding financial contributions gave an indication of the great variety in these arrangements. There was often a combination of block and per capita payments, percentage or deficiency

grants. In many instances the contribution was in kind, such as help with transport or equipment, administrative or clerical assistance or use of office premises.

Trends affecting voluntary effort

1036. Today local authorities themselves provide social services and employ trained social workers. In this way they become informed at first hand of the needs to be met, the problems in meeting them, and the contribution that a trained worker can make. They will naturally expect a similar quality of service from voluntary bodies employing paid staff. If it is true that more is now expected of the statutory services in meeting human needs, this is equally true of voluntary organisations.

1037. Much of the local authority evidence paid tribute to the work of these organisations. At the same time, some of it suggested that the financial and other resources of a local organisation were not always sufficient to build up a new service, or to ensure sound development. Local authorities must endeavour to secure an adequate service, and for this reason, and because of the variety and complexity of needs to be met, many now wish to meet the demands made on the services by employing their own trained and experienced social work staff. This may forecast an extension, and possibly a quickening, of the traditional process by which local authorities take over responsibility for established services which have previously been provided by a voluntary organisation, often on an agency basis. This does not mean that the need for voluntary effort is thereby reduced. It will certainly be needed in new directions beyond the scope of existing legislation, and in working in co-operation with the statutory authority. Some of our witnesses mentioned a reluctance on the part of some voluntary organisations to give up responsibility for a well-established service, even if there was other obvious pioneering to be done. We were also told that on occasions too little effort was made to keep the authority informed of the details of an agency service, or that the staff employed by the voluntary agency were not sufficiently aware of other services to make proper use of them.

1038. The evidence from the voluntary organisations showed that in general they appreciated the wisdom of the process of handing over responsibility for an established service. Some maintained however that this applied mainly to services where the statutory responsibility was clearly defined, as with the blind. They suggested that family casework was concerned with a wider range of needs and of services than those within the scope of a local authority and therefore required a more flexible setting. In the opinion of these witnesses a voluntary family casework agency ensured concentration of effort in the interests of the client without regard to statutory obligation or the limitation of departmental functions. It also enabled an individual or a family to exercise a choice of agency; it was suggested in this connection that many would prefer to seek the help of a voluntary rather than a statutory body. We cannot accept the view that officers of a local authority are concerned only with the services provided by their own department or authority. They, no less than the staff of voluntary bodies, can and do seek the co-operation of all services (voluntary, statutory and the good neighbour) when the interests of their client require it. Nevertheless, we appreciate that in some instances the voluntary body may have a precious

freedom to manoeuvre and even a 'right to be inconsistent' which the local authority is denied. We agree, especially with a new service, that a client may wish to choose between a voluntary and a statutory agency, some preferring one and some the other.

Functions of voluntary organisations

1039. One of the prime functions of voluntary organisations, according to the evidence of the National Council of Social Service, is to experiment, to initiate, and to pass on responsibility to authority if and when this is appropriate. This passing on at a certain point is sometimes a necessary condition if experiment and initiative are to continue. Unless a voluntary organisation is freed of some of its established work it may not have the creative energy to recognise changing needs and to pioneer ways of meeting them; its finances may also be so committed in its long-accepted work that it cannot undertake the risk, and perhaps the unpopularity, that real pioneering often involves. The position of voluntary organisations under the auspices of the churches is rather different in that, in addition to a social work function, they have related pastoral or religious functions which they may rightly feel cannot be passed on either wholly or in part. Another type of voluntary effort which cannot be passed on is found in the various professional associations of social workers and administrators. By making wider use of the experience of workers in the field, these bodies do steady and effective work in identifying unmet needs and making these known.

1040. We have been glad to see on some of our visits that local authorities also initiate and experiment in methods of providing services, but the more radical demonstrations of new ways are, we consider, appropriate to voluntary bodies and are likely to remain their most valuable contribution. We think nevertheless that in all services (whether statutory or voluntary) periodic revision of aims and regular appraisal of the means used to achieve them is required for the proper operation of the service, and as a basis for improvement and experiment.

1041. Another function, which may grow in importance as the statutory social services extend, is to assist the citizen who needs help in connection with a statutory service, perhaps in protesting if he thinks his case has not been treated fairly. A voluntary organisation may act as a watch-dog in keeping the statutory service up to the mark. Similarly, a citizen may need help in explaining his reasons for resisting an unwelcome suggestion even though intended 'for his own good'. We know for instance that local authority officers are most scrupulous in exercising their compulsory powers under Section 47 of the National Assistance Act, yet the old person who is pressed to leave his home, however insanitary, to enter hospital or residential accommodation, however necessary or excellent, may want help in putting his own case to the Court.

1042. At one time it was argued that only a voluntary organisation could provide a personal or a casework service. Professionally qualified case-workers now operate effectively in many statutory services—in child guidance, in child care, in the hospital service, in probation and elsewhere; we have no evidence that they are not equally effective in local authority health and welfare services, provided their functions are understood. The field studies and our own observations make it clear that local authority officers can

provide individual and personal services in carrying out their statutory responsibilities. In short, the decisive factor today is the selection and training of personnel.

1043. The Committee on the Rehabilitation, Training and Resettlement of Disabled Persons recently commented on the work of voluntary organisations for the disabled and some of their views are relevant to voluntary effort in general. The Committee noted that many of these organisations found it difficult, for a variety of reasons, to obtain the necessary funds and consequently relied mainly on payments from the statutory authorities for work undertaken on an agency basis. They did not believe that the proper line of future development, at least in relation to the handicapped, should be simply a large increase in the use by public authorities of voluntary bodies as their agents, partly because voluntary effort throughout the country was too patchy to allow this to be done on a national scale.[1] The questionnaire returns confirm that similar considerations also apply to other services. Furthermore the Piercy Committee considered that any expansion on a grand scale would almost certainly destroy the voluntary spirit. In their opinion the future of voluntary service lay in making the fullest use of its natural suitability for the exploration and development of new fields of work, and in supplying personal interest and care. This kind of care, they suggested, is more difficult to provide through the ordinary machinery of a public welfare service, though not, we think, impossible, or even rare. The Committee suggested that the time was ripe for an inquiry into the nature of the contribution which might be made by voluntary organisations in present circumstances. An inquiry, promoted by the National Council of Social Service and the Central Council for the Care of Cripples, has since been carried out by Dr. J. H. Nicholson, C.B.E.[2] The basic problem, says Dr. Nicholson, is the appropriate place of voluntary service in work for the handicapped in the new situation created by recent legislation. He concludes that there is not, and perhaps cannot be, a general answer to that problem. The solution must be worked out in terms of a variety of activities according to the field of work considered.

Relationship between local authorities and voluntary organisations

1044. The relationship between local authorities and voluntary organisations is usually closest when there is an agency agreement with the latter to provide a statutory service. We are inclined to agree with local authority witnesses that these authorities will increasingly take direct responsibility for providing the services with which we are concerned. This appears to us a logical development of the major changes introduced in 1948. The point has been reached when the greater resources of local and central government are required if the services are to be further developed. But agency agreements are still important and will no doubt long continue to be useful in many areas ; it is therefore appropriate to consider the principles involved.

1045. In providing a service by this means the local authority looks for special knowledge and experience of the needs to be met, for trained or experienced staff, and the assurance of an efficient and economical administration. Voluntary organisations for their part expect understanding of the

[1] Cmd. 9883, paragraphs 336–337.
[2] *Help for the Handicapped.* An enquiry into the opportunities of the voluntary services. The National Council of Social Service (Inc.), November, 1958.

aims and purpose of the service, support in the methods by which it is given, and adequate financial provision. Some of the evidence suggested that sometimes neither partner clearly understood these points ; the voluntary organisation resenting inspection as interference, or the local authority by making only a token grant failing to ensure an adequate service. Apart altogether from their statutory responsibilities in this matter it is important, in the interests of those served, for an authority to make sure by inspection or other appropriate means that the quality of service given is satisfactory. This is fundamental in all formal agreements between local authorities and voluntary organisations whether these apply to the provision of services or to residential care in a voluntary home.

1046. Some evidence suggested that social workers employed by a voluntary agency providing a statutory service should be required to have training and qualifications equivalent to those expected of local authority officers undertaking similar work. At present when most of the officers concerned are themselves untrained, except 'on the job', this question hardly arises but the situation will be different when our long term training plans are implemented. Even now, one authority, in replying to the questionnaire, mentioned declining co-operation with a local voluntary organisation because it did not employ trained social workers.

1047. Our proposals for a general training leading to a National Certificate in Social Work are intended for social workers in the health and welfare services, but training courses, as they become established, should also provide for similar staff of voluntary organisations. This would promote interchange between different services as well as improving standards generally, provided that comparable salaries and pension rights are secured.

1048. We consider next the relationship between local authorities and voluntary organisations where there is no formal agency agreement. The distinction is often a fine one ; the questionnaire returns from two adjacent authorities showed, for example, that both used the same voluntary organisation to provide a tuberculosis after-care service though only one had made a formal agreement. Similar instances were found in the mental deficiency service.

1049. In addition to co-operating in providing a statutory service some voluntary organisations also provide services for which local authorities may have no statutory responsibility, or which can only be effectively provided regionally or nationally, but which play a vital role in a complete service. Such are the advisory and training facilities of the National Association for Mental Health, the National Old People's Welfare Council and Scottish Old People's Welfare Committee, and the regional associations for the blind : the recuperative centres for mothers and children, the Family Service Units, the library service of the National Library for the Blind, and the gadget and appliance exhibitions sponsored or provided by the British Red Cross Society and the Central Council for the Care of Cripples, to mention only a few. Some national bodies also have local organisations or affiliates, such as the British Red Cross Society or the Women's Voluntary Services, the old people's welfare committees and the associations for the physically or mentally handicapped. The services for older and handicapped people provided through voluntary effort include an immense range of pioneer and

experimental work. The old people's welfare committees, for example, have evolved such varied services as visiting, day care, provision for chiropody, laundry and holidays, the new schemes for finding lodgings or 'boarding out', and home helps which supplement or extend the range of the local authority service. Similar services for the handicapped include the help given in social and craft centres, with transport and holiday arrangements and in visiting the homebound.

1050. Whether or not there is a formal agreement there are often arrangements for liaison, usually by chief welfare officers or other appropriate staff serving on the voluntary committee in an honorary capacity. In this way they get to know where the authority's help is needed, and in turn can indicate necessary supplementary services. Local authority officers should always be readily available to officials of voluntary bodies (even if they do not serve on their committees) and occasional meetings of statutory and voluntary field workers are likely to be fruitful. A good working relationship between statutory officers and the organiser of a voluntary service is vital, and time is well spent in cultivating appreciation of the common aims on which such a relationship must rest.

1051. Apart from agency agreements, local authorities also use their powers to assist voluntary bodies by grants and in other ways and, as already noted, we found many examples of such help. Assistance of this kind can be a substantial encouragement and may prove an invaluable method of 'pump priming' voluntary effort in support of a service. Some voluntary organisations find that a few of the more important of their activities, such as staff training, have little public appeal though they are fundamental for sound development. These particular activities may thus be specially appropriate for local authority support. Where grants are at all substantial there rests a continuing responsibility on the local authority to make sure at first hand that a worthy service is being rendered to the public. This does not affect the voluntary organisation's own function in raising funds.

The functions of voluntary workers

1052. The part played by many different kinds of voluntary worker throughout the health and welfare services has impressed us greatly. No figures are available, but we doubt whether there have ever been so many people willing to give their time freely to help both statutory and voluntary organisations which exist to render a social service.

1053. One or two witnesses suggested that voluntary workers might be regarded as 'general purpose social workers' in the sense that they could be organised to supply a range of services for a particular locality. It was also suggested that local authorities might recruit part-time voluntary workers to alleviate the present shortage of trained staff. Suitable married women with children at school were particularly mentioned in this connection. Since voluntary workers already play a large part in supplementing these services we do not believe a scheme of this sort would either alleviate the shortage of manpower in the local authority, or enable voluntary workers to make their best contribution. They could not appropriately undertake work for which the authority has a statutory responsibilty, and there would be considerable difficulties in ensuring training of the standard required. Our proposals for the employment of welfare assistants with planned in-service

training are, we think, more likely to be satisfactory, and to improve recruitment to the services as a whole.

1054. This is not to say that a local authority officer necessarily provides a better service than a voluntary worker, however recruited, but simply that his functions are different. The voluntary worker can play his important part in ways which would not be a proper use of official time. He may be able to devote himself to only a few people but in doing so he can undertake many personal services for which there is no statutory provision—regular visiting to assuage loneliness, or to make it possible for relatives to go out ; driving someone to church, to a handicraft centre, or just for pleasure ; assisting with shopping, changing books or magazines, writing letters, reading aloud to those with failing sight, and so on.

1055. Although we consider that voluntary workers cannot undertake the statutory duties of local authority officers it is clear that they are already making a powerful contribution to the health and welfare services. In some areas, officers of health and welfare departments have stimulated the formation of groups of voluntary workers in services for the handicapped and elderly, especially in clubs and in visiting. The importance of the latter service cannot be over-emphasised.

1056. Regular visiting of both the elderly and the handcapped has become an essential part of each of these services. It is not easy to organise nor to ensure effective continuity. Visiting is not the smooth and simple task it may appear to those who have never attempted it. Most voluntary workers need help and preparation if they are to undertake the work in a way that really assists the client. " Yes, I like visitors ", said one old lady, " but save me from those who show they come only from Christian charity ". The organiser, whether statutory or voluntary, must be in frequent contact with the visitors and regular discussion between groups of visitors can help to deepen their understanding of the needs of those visited. Voluntary workers undertaking regular visiting should be asked to make periodic reports and it should be made clear that attention is paid to them.

1057. Some witnesses considered that experience showed voluntary workers to be unreliable, or that they lost interest after a time, giving up the work altogether. It was also suggested that they sometimes fail to appreciate that standards different from their own are not necessarily worse, and that in any case people have an equal right to choose their own way of life within the limits of the law. ' Human nature is very prevalent ' and there is bound to be something in these criticisms. We think they might often be avoided or removed if voluntary workers were made to feel an essential part of the team in the service with which they are concerned. It should be clear to them that their contribution is important, both individually and as part of the general community effort. There should be someone with whom they can discuss the work or consult on a particular problem. The Piercy Committee may have had this in mind when they suggested (in drawing our attention to the valuable contribution of voluntary workers in the care of the disabled) that we should consider the extended use of voluntary help under the guidance of professionally trained social workers.[1] Dr. Nicholson suggests in *Help for the Handicapped* that the obvious function of the

[1] Cmd. 9883, paragraph 342.

voluntary worker is to relieve the former of whatever duties could properly be undertaken by volunteers.[1] There are excellent precedents for various arrangements of this kind, and scope for extension in all services where supplementary voluntary effort can be used, though this does not affect our views about the recruitment of voluntary workers by local authorities (paragraph 765). We have suggested (paragraphs 1029–1030) that voluntary workers who are in regular contact with a caseworker can play an important part in identifying people in need of help, as well as in making the services known. As the number of professionally trained caseworkers employed by local authorities increases so will the scope for consultation of this kind. We hope that authorities will be prepared to encourage co-operation along these lines, as it has immense possibilities for improving the quality of service given and of preventing old and handicapped people from being cut off from the life of the community.

1058. A considerable number of voluntary workers have relevant experience or training which enhances their individual contribution. This may have been in social work or in teaching, nursing, administrative or commercial life. Others have more leisure because their families are growing up or through the death of elderly relatives. There are also many newly retired people whose experience, ability, and energy make them valued recruits to any form of voluntary effort, but particularly to the services with which we are concerned. The evidence from several voluntary organisations noted that fresh groups of citizens with leisure posed new problems of selection of voluntary workers, as well as further opportunities for service. Some emphasised the necessity of simple in-service training. The experience gained through the training courses organised under the King George VI Social Service Scheme for old people shows that many local organisations and voluntary workers are ready to gain the knowledge required to equip themselves for the work. There has been a similar experience in the training of citizens' advice bureaux workers, and in the training courses for marriage guidance counsellors.

1059. We are in complete agreement with the stress laid by these witnesses and in Dr. Nicholson's report[2] on the importance of selection and training of voluntary workers. Deciding upon the right voluntary worker for a particular type of work requires imaginative use of varied talents and personal abilities. It also involves matching the particular worker with a particular individual or family. We think that if voluntary workers are asked to give regular time, and to take appropriate responsibility there then exists an obligation to equip them to do the job competently. Training is essential if voluntary workers are to give their services knowledgeably and acceptably, and training can help them to feel an integral part of the service. It is particularly important, as the evidence pointed out, if they are to recognise when the situation requires a professionally trained worker or a different service. The suggestions in our training proposals for in-service training of welfare assistants give some guide to the training of volunteers, though the latter would require something shorter, and less concerned with the administration of local authority services.

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[1] *Help for the Handicapped*, page 73.
[2] Ibid., pages 74–75.

Conclusions

1060. We are in no doubt that the continuing vitality and the creativeness of voluntary organisations and voluntary workers are of the utmost importance for the future of the social services, not least for those within our terms of reference. Fortunately, voluntary effort shows remarkable persistence and fertility ; a distinctive feature of the last decade has, for instance, been the growth of organisations concerned with specific physical and mental disabilities. These have come into being both through the efforts of handicapped persons themselves, and by the work of interested sympathisers who recognise and seek to meet the problems arising from the disability, partly by drawing attention to them. The first type of organisation is an example of self-help and mutual aid which provides the reassurance of shared experience, and the stimulus of discovering that common difficulties can be lessened or overcome through common effort. If sufficient resources can be mobilized, either type of body can provide specific services for those with whom it is concerned. The setting up of these organisations to meet specific needs is a healthy sign. They can, however, make for the fragmentation of the services if the importance of common as well as distinctive needs is not recognised. But the winds of voluntary effort blow where they will and are sometimes most salubrious when least convenient for administrative purposes.

1061. A great variety of voluntary services for older people has come into being in the last fifteen years ; there have also been important new services designed to strengthen the stability of family life or for families with special difficulties, to help with the after-care of the sick, and to compensate for the barrenness of social life in the peripheral housing estates. When growth has been rapid and resources have perhaps become too thinly spread, evaluation rather than fresh experiments may be indicated—a study, for example, of the continuity and effectiveness of a visiting or meals services, or an appraisal of club activities or ' boarding out ' schemes. A comparable process may be needed in the services for the handicapped, perhaps with the emphasis on ways of achieving co-ordination and integration of effort : but many of these services are still so largely experimental that they offer particular scope for new developments of all kinds.

1062. The emphasis in the mental health service on community care suggests that the individual time and interest given by voluntary organisations and voluntary workers will be an important complement to the work of psychiatric social workers and mental welfare officers. New and varied types of residential accommodation will be needed, some of a kind of which there is as yet little experience outside mental or mental deficiency hospitals. Experiments will be particularly valuable here. More therapeutic social clubs must be started and new kinds of day activity and sheltered employment in the after-care of the mentally ill and adult mental defectives. As the services for the after-care of the sick become more fully developed new openings for imaginative experiment in voluntary service will certainly be revealed. Special types of long-term and short-term residential care will be needed, or convalescence for those with particular needs, new interests and occupation for the home-bound chronic sick will always be valuable and ways of relieving strain on relatives. The cross-fertilization of statutory and voluntary effort typical of this country enriches each of these services and nourishes all ; it has proved an example and an inspiration for many lands.

Chapter 12

CO-OPERATION: CO-ORDINATION AND TEAM-WORK

1063. Much has been said and written in recent years about the importance of co-operation in the complex system of our social services, and the need for co-ordination of effort and effective team-work. Many points of view have been put to us in the course of our inquiry; in evidence, during our visits to local authorities, and in the reports on the field studies. We also received detailed information on current practice in the use of co-ordinating committees and case conferences. In this chapter we review the present situation and offer some suggestions.

1064. As we see it, there are three main aspects of co-operation; firstly, planning the administration of local authority departments so that there is good co-ordination within departments, common policy between departments and between them and other statutory and voluntary agencies; secondly, the importance of field workers understanding each other's functions, and having direct personal contacts; and thirdly, the need for agreement on the functions of co-ordinating committees and case conferences where such arrangements are in use. Nearly all the difficulties mentioned to us about lack of co-operation or co-ordination arise from failure at one or other of these points.

1065. Some evidence on the use of co-ordinating committees and case conferences clearly showed that the difference in their functions was not understood. Individual workers will therefore have different purposes in bringing a case to either meeting, and this uncertainty will affect the outcome. In our view, and putting two complex processes at their simplest, the functions of a co-ordinating committee are to work out and operate a plan for co-operation in general terms, and to consider general questions of principle or policy. A case conference on the other hand provides the setting for a limited number of workers involved in the case under consideration to assess the total situation or need, to work out a concerted plan of action, and to carry it into operation with each other, and with the person or family involved.

1066. Co-ordinating committees and case conferences in local authority services are the outcome of discussion in the Press and in Parliament in 1949 on the problems of children neglected in their own homes. In 1950, circulars[1] issued by the Home Office, the Ministry of Health and the Ministry of Education jointly, and by the Scottish Home Department, outlined some of the causes of neglect and ill-treatment and reviewed the powers of local authorities to take appropriate action. Authorities were asked to designate an officer to be responsible for securing the interest and co-operation of all concerned both in the statutory and voluntary services. It was suggested that the designated officer should hold regular meetings of

[1] Home Office Circular 157/50, Ministry of Health Circular 78/50, Ministry of Education Circular 225/50; and Scottish Home Department Circular 7497.

these officers, and that significant incidences of child neglect or ill-treatment should be notified to him.

1067. When we started our inquiry it was known that many authorities had made arrangements on these lines, and that some had widened the scope of the meetings to include problems arising in other services. In designing our questionnaire we aimed therefore at obtaining details of this framework for co-ordination, and an indication of the patterns of contact between field workers in health and welfare departments, and with other workers. We also asked for details of any planned case conferences in which officers of health and welfare departments participated, and whether it had generally proved possible at such conferences to arrange for subsequent visiting to be undertaken by one worker. While we were drafting the questionnaire the Ministry of Health, the Home Office and the Ministry of Education informed us of their intention to ask local authorities for a general account of the measures taken by health, welfare, education and children's departments since the joint circular of 1950. Through the courtesy of these departments the replies to the new joint circular were made available to us. We are also indebted to the Scottish Home Department for information about Scottish arrangements.

Replies to the joint circular of 1956 and the questionnaire

1068. The replies to the joint circular of 1956 and to our questionnaire, and the information from the Scottish Home Department, showed that all but 22 authorities had set up co-ordinating arrangements of one kind or another. Details of the type of authority and the various combinations of designated officer, co-ordinating committee and case conference are shown in Tables 52 and 53. Eighty per cent of all authorities had designated a co-ordinating officer; 49 per cent of these were children's officers (one of whom acted as designated officer for 3 Scottish counties), 30 per cent were medical officers of health or area medical officers, and 18 per cent county or town clerks. The distribution of these authorities and the type of co-ordinating arrangement are shown in Table 54.

1069. According to the replies, it appeared that co-ordinating committees were usually large, a few authorities described them as unwieldy. Area sub-committees were smaller and a few had restricted membership in order to limit the size of the meeting. The majority of case conferences formed part of the general co-ordinating arrangements but some were held *ad hoc* for certain services. Fifty-six per cent of authorities in England, 25 per cent in Scotland and 59 per cent in Wales held case conferences. In Scotland most of the authorities who did not hold such meetings were remote counties or islands where the scattered population and multipurpose duties of district welfare officers made this kind of arrangement unnecessary. Similar considerations may apply in parts of Wales, but geographical factors did not appear significant among English authorities.

1070. A small number of authorities in all three countries had set up committees to consider families in temporary accommodation or in danger of eviction; as a rule these also considered other family problems. Fifteen authorities had special committees for the care of old people, in some instances these were advisory or consultative, in others co-ordinating or organising. Some 20 committees were concerned only with co-ordinating

services for the general classes of handicapped persons. These committees are more usually known as associations (see paragraph 542).

1071. The general impression from the replies was that the majority of authorities had found these arrangements helpful. It appeared that as much depended on the skill of the person, or people, concerned in arranging and chairing the proceedings, as on the goodwill and co-operation of those present, especially in the initial stages. There was some tendency to consider the matters under discussion in terms of the 'problem' family alone, and references to other difficulties, or to families which were breaking up under the strain of illness, especially mental illness, or marital disharmony were noticeably fewer.

1072. Sixty-four per cent of authorities said they were generally or reasonably satisfied with their arrangements, the proportion was much the same in counties and in county boroughs. Eighteen per cent considered them only moderately satisfactory and 18 per cent expressed no opinion or were non-committal. A number of the replies were of much general interest and some are quoted in Appendix F. The work of area committees in counties was on the whole regarded favourably, particularly in making workers known to each other, and in improving co-operation with housing authorities. One authority commented on the non-statutory nature of much of the work undertaken, another stressed the value of a small group in preserving confidential matters. One reply included quotations from the annual reports of the divisional medical officers chairing the area sub-committees. Of these, 5 were enthusiastic, 4 considered the committee to have made no essential difference, and 3 were non-committal. One of the first group made the following comment.

> " There are times when one is apt to think that the meetings are quite futile in bringing about any good results. I am convinced that such futility is entirely limited to the short term view and that in the long run the sharing of information brings about beneficial results ".

1073. Where the arrangements had not proved useful reference was made to limited contact with voluntary organisations or to difficulty in persuading them to withdraw from particular cases, to failure by others concerned to notify suitable cases, or to obtaining help and co-operation without the formality of committee proceedings.

1074. There was no uniform pattern either of designated officer or co-ordinating arrangements among the authorities satisfied with their arrangements. Some counties had no designated officers and others no area sub-committees. There might be a main co-ordinating committee and case conferences, or there might be only case conferences held on individual cases. All county boroughs in this group had co-ordinating committees, and some also had case conferences, but not all had designated a co-ordinating officer. No one type of officer was concerned, the designated officers being either county or town clerks, medical officers of health, children's officers or chief education officers. The field workers might be health department staff, child care officers, or, in a few authorities, education welfare officers. Arrangements of interest to us included the appointment of a family case-worker or a 'problem' families officer in the health department (see paragraphs 442 and 444), and proposals to expand the home help service to assist in the prevention of break up of families.

1075. Where the children's officer was the designated officer, or was mainly concerned, suggestions were sometimes made for further statutory powers to undertake preventive work, or to enable financial help to be given to relieve immediate distress, or to provide material help. One reply suggested that there was a growing need for an advisory child care service for families which did not appear on the surface to be obvious recipients of help from the child care service. Such families included

> " (*a*) Children whose welfare is affected by the problems of their parents' divorce or legal separation, or who have been disturbed or emotionally deprived by the life of middle-class parents separated from them for years, due perhaps to appointments abroad or in the armed forces.
>
> (*b*) Children whose parents are near mental cases or severely neurotic but whose financial means are adequate to prevent them from becoming destitute, and those who come to the notice of the children's department through educational sources and who later, upon enquiry, prove to have a far more complicated problem than the immediate cause of referral.
>
> (*c*) Illegitimate children who do not necessarily come into care, but whose early years are a source of considerable anxiety to the child care workers who hear about them.
>
> (*d*) Children who, after referral to a child guidance clinic, appear to need some provision in addition to the social work which is carried out by the psychiatric social worker and normal residential provision as a maladjusted child ".

This interesting comment clearly indicates the need for a family care service so far as our terms of reference are concerned. We think that where health departments see the opportunities for developing social work with families as part of their preventive work many problems such as these would be met at an earlier stage. We have no doubt that some children who are now received into care could have been helped by health or education departments before the need for such action arose. These examples also show the importance of close co-operation between the mental health and other services concerned with the family.

Views expressed in evidence

1076. Some witnesses, speaking from first hand experience, considered that co-ordinating committees which functioned regularly and successfully engendered a team spirit and fostered a genuine partnership between officials and voluntary organisations. Co-ordinating committees also helped to give those attending a better understanding of each other's functions and responsibilities, improved the quality of the service and provided for an exchange of information. There was general agreement that they were better suited to dealing with matters of policy, leaving detailed discussion of individual cases to case conferences or to area sub-committees. Others considered them to be time-consuming and not of great value, that they depended too much on the personalities involved, or that they were ineffective because members with different backgrounds could not speak the same language, and lacked knowledge of the matters on hand. It was suggested to us that some administrators had little appreciation of the functions of caseworkers and their methods of work and, as a result, social workers in different departments were unable to co-operate successfully.

1077. Similar arguments were used by those whose experience of case conferences led them to think such meetings often had little sense of direction, or that a casework approach was lacking because those attending

were not trained social workers. The weight of evidence was, however, in favour of case conferences, and the advantages of discussion were usually considered to outweigh disadvantages such as those mentioned above. It was suggested to us that the essence of a case conference was to bring personal knowledge to a discussion, to make a plan for action, to co-ordinate the contribution of different workers, and to avoid overlapping of effort. Almost invariably there were references to the value of personal contacts and to the way in which these increased understanding. It was also suggested that in order to preserve confidence only the workers actually concerned should attend, that a case conference should always precede reference of a case to a co-ordinating committee, and that the worker chosen to undertake the main responsibility should be the one best fitted (by personality, training and function) to achieve a satisfactory relationship with an individual or a family in difficulty. The social work evidence pointed out that it was essential to match worker to client whenever sustained work was likely to be required, or where the reaction of the client to such a relationship was likely to be decisive.

1078. Discussion of the value of co-ordinating committees and case conferences leads on to the question of local and reciprocal contacts. Our attention was frequently drawn to the necessity for co-operation at local level between officers of housing, health and welfare departments, and to the difficulty of getting in touch with officers who spend much of their time out of the office. The importance of reciprocal contacts at field level was also mentioned; the Society of Medical Officers of Health suggested that poor co-operation often resulted from their absence. One public health nursing organisation, expressing the view that it was the duty of health visitors to provide all necessary information to social workers called in in individual cases, told us that one of their main worries was that health visitors (in view of their continuing responsibility) looked to social workers for reciprocal information which was not always forthcoming. Similar comments were made by others about health visitors. One witness had some hard things to say about the relationship between workers with different training

> "We find considerable resistance in the different branches of field work to co-operation with each other. While it is a basic tenet of casework thought and policy that the caseworker should accept the client as he is, this notion of acceptance of reality does not always seem to extend to the concept of accepting other workers as they are, and accepting their functions in relation to the client".

The nature of the problem

1079. The original purpose of the arrangements under the joint circular of 1950 was to bring together various officers of statutory and voluntary organisations to consider the problems of children neglected or ill-treated in their own homes, the action to be taken, and ways of preventing the break-up of families. The replies to the further joint circular sent out in 1956 and to our own questionnaire show that this procedure has been extended since 1950 and is now being applied to services covering a wider range of need. This expansion confirms our own view that the general principle of co-ordinating machinery is sound as applied to local authority services.

1080. The varying views expressed in evidence indicate the need for a systematic study of co-ordinating committees and case conferences in relation

to the general structure of local government, and to the needs of those using the services. Research is required here as elsewhere; we **recommend** that this should be undertaken.

(a) *Co-ordinating committees*

1081. The replies to the joint circular and our questionnaire suggest that in this, as in other matters, no one pattern of co-operation will be appropriate for all areas. If good co-ordination and co-operation can be achieved by other means there may be no need for formal machinery: it is also better not to have a co-ordinating committee at all than to have one which is unsuccessful. We have defined the function of a co-ordinating committee as to work out and operate a plan for co-operation in general terms and to consider general questions of principle or policy. Some of the committees or associations for the handicapped referred to in paragraph 542 above have functioned successfully on these lines. In general, however, Dr. Nicholson in his report commented that much more needed to be done in this field, and recommended the establishment in each county or county borough area of an association fully representative of the statutory and voluntary services concerned.[1]

1082. Whatever arrangements are considered appropriate to each area we think it important that they should be sufficiently flexible to promote co-operation whenever new policy or principles affect more than one department. The committee would lay down the pattern for co-ordination and approve subsequent action. In counties it might, for example, agree a general policy with housing and other authorities on ways of preventing eviction, or of identifying families where arrears of rent might be the first sign of incipient breakdown. This kind of policy-making committee might only have to meet two or three times a year. It would not want, or need, to know the details of individual cases, except insofar as these illustrated some difficult issue of principle, when discussion would centre on the principle not on the case as such. There are grave dangers if such meetings, which represent a wide range of interests, discuss individual cases in which those present are not actively or professionally concerned. Such discussion may also lead to leakage of confidential information about the affairs of the individual or family concerned. We were told of one committee to which field workers made written reports through senior officers but did not themselves attend. There was much discussion on confidential and other matters, although no one had any find hand knowledge of the problems, or of the individual families concerned. Eventually decisions were reached, which in some cases seemed inappropriate, and the field workers were instructed to put them into effect. This is obviously neither co-ordination nor co-operation and an indefensible use of a co-ordinating committee. Nevertheless the same committee had done good work at a higher level in bringing the various services together, and in discussing matters of general policy and common interest. If the distinction we have made between co-ordinating committees and case conferences is kept in view this confusion about function need not arise.

1083. Another, and so far little recognised, function of co-ordinating committees would be to look at the changing pattern and inter-relation of the

[1] *Help for the Handicapped*, pages 104–105.

social services which might call for social inquiry or research, and the changing social problems and needs of different localities within the area as, for example, when families are rehoused on a new housing estate. They could promote joint discussion and planning on making the services known, or in resolving difficulties arising from the varying approach of different services. They could also improve understanding by discussion of other common problems, and provide a useful forum for information, for example, on new legislation or interesting experiments being conducted elsewhere. We heard of one committee which invited the clerk of a district council to explain and lead a discussion on the Rent Act, 1956. The implications of the Local Government Act, 1958, in terms of local co-operation, would seem an appropriate subject in certain areas at the present time. In a few authorities the functions of a co-ordinating committee are to some extent fulfilled by a chief officers' conference. It was suggested to us that co-ordination can often be better achieved by this means with less expenditure of time and money, and greater safeguards in preserving confidence. This system can play an important part in influencing departmental attitudes and also promote co-operation from the top down. It does not, however, fulfil all the functions of a co-ordinating committee, since officers from statutory and voluntary agencies outside the authority would not normally participate.

1084. The ability and influence of the chairman is a vital factor in the success of these committees. We do not think the designated officer need necessarily act as chairman, but whoever does should have a grasp of the social questions involved, and the ability to discuss administrative issues with an open mind. The chairman should ensure that committee members understand the limitations of the committee as well as its functions—that is to say that they do not get bogged down in detail, or stray into discussion of individual cases excepting in as far as these illustrate general principles. We do not feel able to draw conclusions from the limited information regarding chairmen in the replies to the questionnaire, but we have no doubt that a co-ordinating committee requires an exceptionally skilled and experienced chairman.

1085. Replies to the questionnaire showed that occasionally local authority members attended but that normally committees were composed of chief officers together with other senior staff. Outside representation was generally wide, including officers of other statutory bodies and of national and local voluntary organisations. We have given some thought to appropriate representation; if these committees normally discuss general issues and do not confuse their functions with those of a case conference, there is much to be said for membership being representative of as many interests as the type and needs of the area require. This implies that normally all those present would be chief or senior officers, and that field workers would not attend. In this event there might well be occasions, as for example in the discussion on the Rent Act referred to in paragraph 1083, when it would clearly be useful and economical for field workers or other staff, whose work was likely to be affected by impending changes, to be present. There might also be occasions when the needs or problems of a particular area were being discussed and it would be valuable to have the contribution of the field worker's first-hand knowledge. Attendance at these or similar

meetings of a co-ordinating committee could be regarded as an element in in-service training. If an individual case necessitated a policy decision by the co-ordinating committee we hope that the field workers concerned would always attend to present the case and to supply such additional information as the committee might require. Other than this, we think their essential contribution is more appropriately made at case conferences.

(b) *Case conferences*

1086. We have defined case conferences as a means of assessing the total situation in individual cases, of enabling the workers concerned to make a plan, and to assign responsibility for carrying out the action required. Case conferences were first developed in the United States where they play a well-recognised and important role in social work. The essence of a case conference in that context is discussion on equal terms by caseworkers with a common background of knowledge, sometimes assisted by a psychiatrist. In this country they have been used in child guidance clinics and mental hospitals, where a psychiatrist usually takes the chair. To a more limited extent they have also been used in other hospitals, as for example in resettlement conferences for the rehabilitation of the sick or disabled, in industrial rehabilitation units, and also in the probation service. In the local authority they have been mainly used, as we have seen, for 'problem' families, and in situations where children are neglected or ill-treated in their own homes, or deprived of a normal home life. There is in our view a place for them in other work with families, including unmarried or unsupported mothers, in the mental health service and with elderly people (sometimes before a decision is reached on admission to residential care). They are also desirable in the care of the physically handicapped.

1087. Replies to the questionnaire showed that few hospital staff attended local authority case conferences. It will often be advisable to bring them in because of the inter-relation of social and medical problems. One example quoted to us described the following situation.

> (20) A family where the father, a young man with poor sight since childhood, was trained as a blind capstan lathe operator at a Ministry of Labour training centre but had periodic spells of unemployment. His wife became depressed and a good deal unsettled during successive pregnancies, and on one occasion while pregnant was ill enough to be admitted to a mental hospital as a voluntary patient. The eldest of the three children was epileptic, the second was taken into care temporarily by the children's department while the mother was in a general hospital having the third child, a delicate baby needing much care. The family was in touch at the same time with a home teacher of the blind, a mental welfare officer, a health visitor and a child care officer, and during the same period with two hospitals, a voluntary children's society (to whom they had offered the second child for adoption) and the National Assistance Board. None of the workers have ever met or discussed the family's problems, and no one appeared to have suggested a case conference to assess the complex inter-relation of need, to work out long term plans and to decide which worker could most appropriately carry the main responsibility in co-operation with the other services involved.

Not all situations are as complex as this. We think however that among the handicapped or chronic sick, particularly the young, there are many whose needs involve a number of different workers and whose problems should be discussed at case conferences between those directly concerned. Otherwise there is a risk of decisions being made on paper, without sufficient account being taken of the personal or social aspects of the situation, or the desires of those most concerned.

1088. When we say that one of the purposes of a case conference is to work out a plan in relation to a particular situation we are far from suggesting that people's lives should be planned for them behind their backs and without their having any say in the matter. Our concern is that different workers should not act without a thorough assessment of the needs of the situation, the goals to be achieved, and the means by which they may be reached. We regard full discussion with the persons concerned, and gaining their co-operation up to the limits of their capacity, as essential both in planning social action and in the methods used to carry it through.

1089. It is not in our view appropriate for members of statutory or voluntary committees as such to attend case conferences. Membership of these conferences should normally consist of all field workers in a locality, but only officers actively involved should attend when any given case is being discussed. The chair should be taken by an officer who understands the purpose of a case conference and has most experience in this field. He should be able to give a lead so that discussion is focussed on the most significant issues in the particular case. Some of us attended a case conference where all those present criticised the social inadequacy of a certain family, and the inability of the father (who had been deserted by the mother) or his daughters to run the home. No one appeared to notice the probable creation of a new ' problem ' family foreshadowed in the illegitimate child of the eldest daughter. It is likely to lead to more constructive action in studying these situations to try to assess the strengths in the family, and how to work with them, rather than to single out weaknesses in order to condemn them. The training we recommend should include some teaching on ways in which a case conference should be organised and used, and the particular role which the chairman should play. Similar discussion would be particularly useful at refresher courses.

1090. We have mentioned elsewhere (and particularly in paragraph 606) our views about the importance of confidential discussion and record keeping, and we think that confidentiality should always be strictly preserved. We were surprised to find this mentioned in only a few of the replies to the questionnaire, though difficulties of this kind were stressed in evidence by both medical and social work organisations. Preserving confidential information is generally recognised as fundamental to a professional relationship and we regret that the implications do not always seem to be clearly appreciated at the present time. There should be no difficulty about it. The principle has long been accepted in the relations between a doctor and his patients, and we see no reason why the fact that a family is in other serious difficulties should not be regarded as being quite as confidential as the relations of its members with a doctor. This applies not only to case conferences but also to conversations in public places which may be overheard. Health departments have always respected the confidential

nature of the diagnosis of tuberculosis and venereal disease ; children's departments take the same attitude in relation to adoption and boarding out. It is true that this needs careful consideration and planning in relation to family problems, especially when some of those attending the meeting may not have had a professional training. Nevertheless it should be possible for information in committee papers to be so presented that individuals, or families, and their addresses are not identifiable. We **recommend** that authorities which have not already done so should review their arrangements and consider how confidence can be effectively preserved.

(c) *Co-operation and referral between workers*

1091. A case conference is usually an *ad hoc* gathering but some, as the questionnaire returns showed, meet regularly, and appear to be used for general purposes. Regular meetings of field workers in a compact locality (whether described as area sub-committees, case conferences or social workers' discussion groups) are, as some of our witnesses suggested, immensely valuable in helping workers to get to know each other and to understand each others' functions and responsibilities. When our field inquiries were being planned it was usual for the field investigator to meet small groups of the workers covered by our terms of reference to explain the purpose of the survey and to seek their co-operation. In one area it was clear at these meetings that some of the workers concerned had never met each other face to face before, though all were employed by the same authority. On another occasion, discussion revealed that some officers in the health and welfare departments had only the vaguest understanding of the powers and responsibilities of the children's department.

1092. If these are not isolated instances they cast some light on the comments made to us about unwillingness to refer, or the reluctance of some workers to seek the advice, or bring in the contribution, of another type of worker. Recognition of the point at which another worker should be consulted or a different service is required is essential in social work but this seems to be too rarely accepted. This is sometimes said to be a limitation of untrained officers but, as the witness quoted in paragraph 1078 pointed out, reluctance to co-operate with, and refer to, other kinds of worker is not found only among the untrained. We think that full co-operation (including referral) will follow only from common understanding and common purpose, and that unwillingness to refer is sometimes related to previous experiences. The chief officers' conference referred to in paragraph 1083 could be one way of encouraging the idea that there is no loss of professional dignity, or of face, in knowing when a particular problem is beyond the capacity or responsibilities of an individual worker or service, or when it would be helpful to consult with another worker in the same or a related field. A research worker will always call in a statistical expert if needed, just as a general practitioner calls in a consultant, or one consultant asks another to take over a case. The principle is the same. We think that lack of clarity in the function of social workers and others may be one cause of conflict, uncertainty and failure to refer.

1093. There may also be difficulties which are partly due to departmentalised services and departmental attitudes. We even came across instances in which it was a matter of pride to keep information from another department

rather than to work in co-operation with it. One of the advantages of the wider grouping of functions, recommended in Chapter 6, is the effect which it should have on modifying a specialised point of view within a service or a department, and thus aiding co-operation and referral. Officers who share a common training are more likely to appreciate the need for co-operation because they accept the common principles in a variety of settings. Shared services can have a somewhat similar effect between departments, or between an authority and an outside body. The war-time appointments of social workers made by some counties to undertake work in the evacuation and billeting services administered by the district councils usually worked well. Some such arrangement will no doubt be needed in areas where county council functions are delegated under the Local Government Act, 1958. Replies to the questionnaire showed some examples of the sharing of staff between local authorities and voluntary organisations, and between local authorities and hospitals. We discussed the sharing of services generally with many of our witnesses. The consensus of opinion indicated that arrangements of this kind were usually helpful. The organisations connected with the mental health services were especially anxious, in the interests of continuity of care, that the advantages of joint use of staff by mental hospitals and local health authorities should be further explored. We have recommended (paragraph 673) that these arrangements should generally be encouraged.

1094. We have said in paragraph 1085 that the contribution of field workers is most effectively made at a case conference, and in fact replies to the questionnaire showed that such officers are usually the most regular attenders. They should always be able to suggest that a conference would be desirable in any given case. According to our information, it fairly frequently happens that a problem does not reach a case conference in time—families who have become homeless are an obvious example. If they have been evicted from council property there must inevitably have been a period of deterioration before action was taken by the housing authority. If they are evicted by a private landlord, advance notice of the eviction date can usually be obtained through good liaison with the clerk of the court, or by keeping a watch on court cases reported in the local press. If eviction has already taken place and the family is in temporary accommodation, the sooner a concerted plan is worked out the shorter the stay is likely to be. Clearly administrative channels are of great importance here. If the relationship between administrator and field worker is to be effective in promoting co-ordination of effort both at the centre and the periphery, then each must keep the other informed. We do not suggest that elaborate or detailed reports are required but there should always be two-way communication. Whether the necessary contacts with a related service are arranged centrally or at field work level is a matter of the best administrative practice in the circumstances. Direct contact betwen field workers is normally the quickest and most effective way of obtaining results, though this is a matter for consideration by individual authorities.

1095. The basis of good co-operation and team-work depends, as we suggested in paragraph 413, in part on ease of contact between field workers. In the questionnaire we asked whether those in the health and welfare services usually got into direct touch with others, or made contact through a supervisory or chief officer. Table 55 shows that, generally speaking, direct

contact between field workers is more usual in England and Wales than in Scotland, in towns and cities than in counties, and with members of the same department than with members of other departments or outside organisations. Direct contact is usual within health and welfare departments in the majority of authorities, and in almost all English and Welsh county boroughs, but even so contact through a supervisory or chief officer may be the more normal procedure. A few authorities noted that although their field workers could get in touch with other field workers in outside organisations it was usual for such bodies to approach the chief officer rather than go direct to a member of his staff.

1096. Some of the returns showed that all correspondence was channelled through a senior officer, or that letters went out only over the signature of the chief officer. We are aware that there are differences in practice in this respect. It has been put to us, however, that this is one of the factors which makes it difficult to attract professionally trained social workers to local government service, since direct correspondence between worker and client (or between professional workers) is regarded as an integral part of the professional relationship, especially where confidential information is involved.

(d) *Multiplicity of visiting: team-work*

1097. The importance of patterns of communication lies in their effect on co-operation generally, and also on multiple visiting of an individual or a family. If one field officer has to go all the way up and down the administrative channels to make contact with another field worker, the chances are that he will simply visit himself without spending time in discovering if his colleague is also doing so. In the replies to the questionnaire about agreement on visiting by one worker, the general view was that it could be arranged, but the replies were often qualified by " if appropriate ", " in some cases ", or " occasionally ". Others did not consider an arrangement of this kind possible, pointing out that some officers had a statutory duty to visit, or that more than one type of worker was sometimes needed.

1098. There has been much talk of multiplicity of visiting and overlapping of effort, and the whole problem of co-operation is sometimes regarded as being mainly one of avoiding these particular hazards. Much of the evidence on this point suggested that current views are over-stated and unsubstantiated. Some witnesses pointed out that it is often desirable, and unavoidable, that there should be some overlapping of function to ensure that varying needs are met. It was also suggested that a household with a complexity of problems was no argument for one worker; the more problems there were, the greater the number of skills required. Other evidence pointed out that even with a case conference there might still be a number of different departments whose officers could not be discharged from the responsibility of visiting in a particular case. One witness quoted a previous Minister of Health who, in discussing criticisms that too many officers visited families, said

> " In my view what is wrong is not that many people are concerned—indeed some of the more baffling problems may require them—but that they should individually think it possible to advise the family individually without having first worked out the co-ordinating plan of action. It is the old story of more teamwork ".

1099. We were interested in a recent survey by the London County Council to establish the extent of duplication of effort in home visiting, and to discover how far overlapping of functions existed. The findings showed that among families previously identified as 'problem' families multiple visiting, in the sense of visits by more than one worker a month, occurred in about 45 per cent, and in the sense of visits by more than two workers in the month in about 15 per cent of such families. Multiple visiting did not necessarily indicate over-lapping of duties since each worker might have a legitimate interest in visiting the family. The officers mainly concerned with these families were the health visitor, the school inquiry officer and the voluntary worker from the children's care committee. The results suggested that multiple visiting, where it existed, was related to the number of children in the family and their age distribution, but that the social characteristics of the family did not appear to be a material factor. There was some evidence that the workers concerned were sometimes unaware of the interests of, or of visits paid by, other workers to the same family, or of the assignment of responsibility for an individual family to a particular worker. In the Council's view, the most important finding in the survey was the need to improve co-ordination of effort, and questions of multiplicity of visiting or overlapping of duties were considered subordinate (though related) problems. There were broadly similar findings in Bristol some years ago in a survey[1] with regard to comparable families.

1100. These conclusions agree broadly with our own view, and with that expressed by one witness, that the difficulty is not so much multiplicity of visiting as multiplicity of independent and unco-ordinated visiting. This seems to us the crux of the problem. We think a distinction should be drawn between over-visiting and overlapping of visits, which may lead to the giving of conflicting advice, and visits by different types of officers who may all be needed. An example of the former quoted to us concerned an unsupported mother with young children visited by a local authority officer who advised her to stay at home and look after her children, and by an officer from another statutory authority who told her she should go out to work to support her family. An illustration of the latter was described to us as follows.

(21) A case conference held in a small town to consider a family situation was attended by field workers from health, welfare, children, education and housing departments of a local authority, a probation officer, an inspector of the National Society for the Prevention of Cruelty to Children and a psychiatric social worker from the mental hospital serving the area.

The family was referred by the education department because of the persistently irregular school attendance of an eight year old boy. During the discussion different members of the conference, speaking from first-hand knowledge of the family, between them gave an account of the family setting which threw light on the school attendance problem. The boy, born four years before his mother's marriage, had been brought up by her during these years in the home of the maternal grandparents. The mother, a psychopathic personality, was

[1] " A Note on Multiplicity of Home Visiting by Medico-Social Workers ", R. C. Wofinden (1954) *Medical Officer*, **91**, 83.

now married to a man with a history of irregular employment interspersed with terms of imprisonment. The health department and the National Society for the Prevention of Cruelty to Children had been concerned from time to time about the inadequate care of two younger children born of the marriage. The family had recently been evicted from a council house because of rent arrears and were now living with the maternal grandparents in condemned property.

The immediate problem of school attendance was resolved by transferring the boy to a school nearer his maternal grandparents' home, and by the education welfare officer enlisting the help of the grandmother and the school teacher in providing some more stable influences to counteract the effect of disturbed family relationships. Another worker began intensive work with the family to clear the rent arrears. When this had been achieved the housing department agreed to rehouse both families sufficiently near together to enable the grandparents to help the mother in the care of the home and children, on the understanding that one worker should, by general agreement, continue to be responsible for supervision.

In some situations such as this more than one visitor may ultimately be required but only one should undertake to gather any additional material on which the initial assessment of a problem is based—in the words of one witness only one worker should go 'to see'.

1101. It has been suggested that regular visiting is sometimes an element of over-visiting. We think there may be instances where the need for visiting is too easily accepted, and we have suggested (paragraph 574) that the need for such visits should be reviewed from time to time. It has also been put to us that straightforward visiting is sometimes allowed to take precedence over the difficult case in which a worker is uncertain how to help. We have no evidence on this but if it is so—and most social workers are at times faced with very serious and complex situations—our suggestions for the use of experienced caseworkers as advisers or consultants should help to reduce this risk.

1102. Co-ordination of visiting is simply good team-work. No-one denies the need for team-work, but it is often thought to be something that depends on everyone except the individual worker concerned. People do not normally feel part of a team unless they are confident of their own function and understand that of others. They must also be able to appreciate the effect of the combined operation. In social work, as in administration, there must be clearly defined procedures, working methods and a division of responsibility according to the functions of each member of the team. Deciding who should be the key worker in each case is one of the functions of a case conference ; another is clarifying responsibilities so that all the other workers involved see themselves as members of a team rather than as representatives of different, and perhaps rival, services. In their evidence the Public Health Section of the Royal College of Nursing put the matter of team-work admirably.

> "Social workers, health visitors, doctors and all those working with the community and for the community should accept each other as friendly professional colleagues, willing to discuss, defer and refer, in order to ensure the best possible service to those whom all serve".

Conclusions

1103. Co-ordinating committees were started in order to secure better co-operation. They are thus simply one instrument in securing an essential purpose of administration. To bring about co-operation is a question partly of administrative structure and partly of the means available to facilitate communication and good relations. Communication is itself an essential element in good administration ; it implies that each person concerned is given the information needed in order that he may fulfil his function. This means planning, and periodically reviewing, the formal lines of communication. It also requires something rather more elusive in that good human relations are part of good administration. Clarity about functions, and appropriateness of function in relation to the work to be done, also facilitates communication and good working relations. The same is true of common understanding, and, in professional matters, a common code of ethics.

1104. The evidence we have reviewed in this chapter suggests, as might be expected, that officials are more likely to co-operate when they know each other, and by common discussion of a problem develop common purposes, though their functions and methods may be different. Discussion can also help to decrease inter-departmental rivalries (where these exist) and facilitate the flow of information between departments. The elements in good team-work are thus: an administrative structure which facilitates co-operation ; good working relation betwen different types of officer and between different departments, and opportunities for regular meetings and discussion at all levels. We have been surprised by the absence of regular staff meetings in many departments. Such meetings are now widely accepted in other spheres as a necessary means of bringing about the purposes outlined above, as well as providing opportunity for exchange of information and discussion of relevant issues. In appropriate circumstances team-work also implies various and planned methods by which the contribution of related professions are co-ordinated in the interests of individual clients, or to further better performance as a whole. An example is the team of psychiatrist, psychologist and psychiatric social worker in child guidance clinics, where integration is achieved through certain common content of training and practice and a shared place of work. It is less easy, but not we think impossible, to bring about a similar integration of effort in the services with which we are concerned, and to relate this to the other services involved. There is much scope for future experiment and development in this field.

PART V

Chapter 13

ADMINISTRATIVE AND FINANCIAL CONSIDERATIONS

1105. It remains for us to consider the administrative and financial implications of our recommendations. A number of them will involve additional expenditure, but we do not think sufficient information is available on which exact estimates can be based. It is clear to us, however, that additional expenditure is unavoidable if the purposes for which the services are designed and which Parliament had in mind in creating the present statutory framework are to be met. Thus our proposals are directed at making it possible to operate existing services more effectively, rather than proposing anything new. We have been careful to recommend only what we consider strictly necessary to ensure an efficient and economical service.

1106. Expenditure incurred in providing an improved service will be to some extent offset by savings in other directions. Everyone is aware of the heavy cost on public funds of providing residential care, of receiving children into care, and of 'problem' families, to name but a few of the most familiar instances. We consider it likely that a substantial, though at present incalculable, proportion of this cost could be saved by better preventive work in the early stages and by the more fully integrated effort of statutory and voluntary services. In this way some homelessness and some family break-up could be prevented, and some older people could be helped to go on living at home for a time after they would otherwise have needed residential care. It is evident to us that there is much scope for the kind of preventive services of which we have seen examples in the course of our inquiry. Earlier discharge from hospital and other institutions may also be possible if adequate after-care is available.

1107. Our recommendations are interdependent and designed to be implemented as a whole. For our present purpose they may be considered under five main headings according to whether they relate to the increased demands likely to be made on the services in future: to the improvement of working conditions: to better deployment of resources and co-ordination of effort: to the provision of training so that in time trained workers will be available: or to the need for research, in particular for detailed studies of aspects of social work in these services.

INCREASED DEMANDS ON THE SERVICES

1108. An increased demand on the main groups of services is inevitable largely, but not wholly, as a result of the recommendations of the Committee on the Rehabilitation, Training and Resettlement of Disabled Persons and the anticipated expansion in community care of the mentally disordered. In addition, an increasing number of older people in the population will

need domiciliary or residential care, while an expansion of work with families is also required. We have also indicated that we think large numbers of the officers within our terms of reference are at present carrying excessive case loads. Some savings might be made by grouping of functions, and by other improvements which we discuss in paragraphs 1112–1117. Nevertheless it seems likely that in a number of areas extra appointments will be called for to reduce case loads to manageable proportions. Furthermore experience shows that, as services develop, hitherto unrevealed (but none the less real) needs are brought to light. Our recommendations for making the services better known will increase the number using the services, and may also help to make these unrevealed needs apparent. For all these reasons we have recommended that staff should be approximately doubled in numbers over a ten year period—an increase at an average rate of 10 per cent per annum though it could only gather momentum as trained workers became available. This figure, adjusted for expenditure on improving conditions of work, provides a rough measure of the financial cost in salaries, office accommodation and other related expenditure.

1109. We have suggested that local authorities should consider employing more part-time workers, including married women, as one means of meeting increased demands. We do not minimise the difficulties of arranging this but they have been successfully tackled in other fields. We also recommend that authorities should consider afresh how far they might appoint women to posts traditionally held by men, and vice versa, in the interests of increased flexibility in recruitment and staffing.

IMPROVED CAREER PROSPECTS

1110. We include under this heading recommendations about salaries and promotion prospects. These will involve a comparatively small financial outlay. We have not made detailed recommendations on salaries but have suggested that certain anomalies should be corrected ; that where career prospects are limited, salary scales should give due recognition to experience ; and that incentive payments should be made to officers who successfully complete a recognised training in social work.

1111. Our recommendations for the improvement of career prospects include the establishment of senior casework and advisory posts and, where appropriate, opportunities for field workers to acquire experience in administration. They would thus become eligible for administrative posts, including posts as chief welfare officer, or (in authorities where responsibility to the council and general oversight of National Assistance Act services rest with the medical officer of health or county or town clerk) as senior welfare officer responsible for day-to-day administration of the services. These recommendations have administrative as well as financial implications. We regard them as essential to improving the quality of service given and to recruiting sufficient new entrants of the right calibre.

DEPLOYMENT OF RESOURCES AND CO-ORDINATION OF EFFORT

1112. Many of our recommendations are designed to ensure that social workers in these services are used to the best advantage. They include recommendations for better transport, clerical assistance, and office facilities ; for the employment of workers with different types of training and experience

to take more or less complex cases ; for a broader grouping of functions ; and for improved co-operation between workers in different local authority services, statutory bodies and voluntary organisations. Some of these call for additional financial expenditure, but the total balance sheet may show a financial saving. Many problems of administration and organisation will however have to be solved if these measures are to be fully effective.

1113. We have recommended the better provision of transport (or payment of allowances for the use of the worker's own car), of clerical help, of office telephones, and of privacy for interviews—facilities already provided in varying degrees by many local authorities. Improved transport is needed to make the most economic use of the time of the trained workers. There may be some increased financial outlay in some areas but this should be offset to some extent by saving in working time. Our proposals for providing improved clerical help will have a similar effect, though the emphasis here is as much on improved efficiency, and on better record keeping. We do not think that the cost of office telephones and facilities for private interviews is likely to be great. The difficult question of the confidentiality of records will require careful consideration and may involve a measure of expenditure.

1114. We have recommended the employment of three main grades of worker corresponding to the categories of need in those using the services. We envisage that social workers with the new general training will undertake much of the work of officers at present employed as welfare officers or mental welfare officers, but that the pattern of staffing will be more flexible. In particular, we recommend that functions at present undertaken by workers with a specialised training should increasingly be undertaken by officers with a general training. The effect of these recommendations should be the better use of trained staff as well as a better service to the public. We recommend that the most difficult work should be carried by social workers with advanced qualifications who should also act as advisers, supervisors and consultants to less experienced or newly qualified workers. Straightforward work should be undertaken in future by a new grade of staff, referred to as welfare assistants, who would relieve trained workers of some of their simpler tasks. Once facilities are available for the systematic in-service training of welfare assistants, their employment should effect some significant economies.

1115. We have recommended that social workers with advanced qualifications should be available to advise and help officers in other services beside their own. This will imply flexible administrative relationships between departments, sometimes more flexible than at present. We have suggested that authorities with such staff should help neighbouring authorities by offering an advisory service, and that arrangements for sharing the services of mental welfare officers and psychiatric social workers with the hospital service should be encouraged. This again implies flexible administration and a desire to co-operate.

1116. We regard the practice of using co-ordinating committees to consider general questions of principle or policy, and also of holding case conferences in appropriate cases, as an essential element in an effective service. We would expect that, provided these are properly constituted and the proceedings adequately planned, the time spent in attendance will be justified in terms

of better service to the public, as well as improved economy in the use of trained staff.

1117. We also make recommendations on the importance of close and easy communication between social workers and others at field level, both within local authority departments and between departments, as well as with workers in voluntary organisations and other bodies. In many authorities such contacts exist already, though we have little doubt that there will always be a need from time to time to make sure that they are as effective as possible. In others, however, the administrative structure of departments makes contact more formal and less easy. Where this is so we recommend that such administrative arrangements should be reconsidered in the interests both of efficiency and of those for whom the services are being provided. We have also recommended regular staff meetings and various other means of continuous in-service training where staff may come to know each other. We have attempted to define the functions of social workers in local authority health and welfare departments, and their relationships with other workers in these departments and in related fields. Local circumstances naturally result in local differences ; what is needed, in our view, is a clear understanding in each area of the function and scope of each type of worker.

TRAINING

1118. We have recommended that social workers in local authority health and welfare departments should be trained in one of two ways : either by taking university social science courses followed by professional courses, or by taking a new general training provided outside the universities for a National Certificate in Social Work. We have estimated that facilities should be provided on a scale to enable 540 new recruits each year to commence training for the National Certificate and that in addition rather more than 1,000 officers in post should take this training wholly or in part over a period not exceeding 10 years. We have also recommended in-service training for welfare assistants on appointment, and a variety of refresher courses and other short courses for present staff. These would include refresher courses in supervision, and other advanced courses for senior staff.

1119. We are well aware that these proposals will involve expenditure both of central funds and of local authority monies, and that local authorities will have to solve many difficult problems of administration and organisation. This will be particularly true in the next few years, when numerous present staff, as well as new recruits, will require training. Nevertheless training is urgently needed. We have accordingly made our recommendations, though with full appreciation of the difficulties involved, at the level which we consider absolutely essential if an adequate service is to be provided.

A National Council for Social Work Training

1120. We have recommended that a National Council for Social Work Training should be set up to sponsor and promote training. We have recommended immediate legislation to enable such a Council to be financed from central funds, and to empower it to give financial assistance to training bodies and students. The costs would include the salaries and expenses of the secretariat, running expenses generally, part of the cost of some refresher courses, and in-service training, demonstrations, publicity for recruitment, provision of teaching materials and the financing of the

Council's activities generally as they develop. The establishment and functioning of this Council will call for close collaboration between Government departments, local health, welfare and education authorities, universities, training bodies and voluntary organisations, both centrally and locally.

Release of officers to take training

1121. We have estimated that about one-third of officers at present in social work posts should be eligible to take the general training for the National Certificate in Social Work, either wholly or in part. To complete this programme within 10 years we estimate that, from the time when adequate training facilities are available, about 8 per cent to 10 per cent of existing staff will at any one time be taking this training on part-time release with a lightened case load, and short periods of full-time release. A very much smaller number, between 1 per cent and 2 per cent, will be taking full-time courses. These will need full-time release, the majority for one year, but a proportion for two years. The total effect will be an average reduction of effective manpower for several years of from 5 per cent to 7 per cent, at a time when there is likely to be an increase in the demand on certain services. We do not wish in any way to minimise the difficulties which will be entailed, in particular to authorities with small staffs, in releasing officers for training while continuing to provide adequate services. To some extent these will be eased when new recruits with the general training begin to enter the service, but the need to train existing officers is so urgent that a start must not be delayed. Training should be looked on as a long-term investment, justifying local authorities in putting every effort into overcoming the immediate difficulties.

1122. We have recommended also that some experienced staff should be released to take short training courses in supervision. The number of suitably qualified officers available is likely to be small. We do not underestimate the difficulty of arranging for the release of officers who are already fully occupied. Adequate facilities are crucial in the provision of training. We would regard this also as a long-term investment which would amply repay itself in terms of making more trained staff available. Moreover, as social workers are trained, and gain experience, the extreme shortage of supervisors will by degrees right itself.

Provision of in-service training

1123. We have also recommended a considerable extension of planned in-service training which would take many forms, including short intensive courses for newly appointed welfare assistants. Some of these would impose no great strain on authorities' resources. There may, however, at times be real difficulty in making available the services of experienced officers to plan and take part in in-service training. All such continuous training must be adequately planned and directed with a clear objective in mind. The implications are, in other words, administrative as well as financial.

Provision of facilities for field work training

1124. We have recommended that students taking the general courses for the National Certificate in Social Work should have field work placements in local authority health and welfare departments as part of their practical training. We most earnestly hope that local authorities will be willing to

provide the supervisors and other necessary facilities. We have suggested a vigorous policy of recruitment of social workers who have taken one or other of the professional courses, some of whom might act as supervisors. When the training programme for the National Certificate in Social Work is fully under way about 1,200 placements will be required annually, some of which should be in mental hospitals or with voluntary organisations. A number will also be needed for social science students and for those taking university or other professional courses in social work. These field work placements must be near a training centre; it seems likely therefore that they will have to be provided by a limited number of local authorities. The benefit will be shared between all authorities by whom these students are ultimately employed.

1125. We have also recommended that more field work placements in local authority health and welfare departments should be available to students taking university social science courses, and also, at the required standards, for students taking professional courses.

Financial assistance for training

1126. We have recommended legislation to enable grant aid from central government funds to be made available to candidates to train for social work in the local authority health and welfare services, as it is already for those who intend to enter the probation or child care services. Before this legislation takes effect there will remain a need for liberal grants by local education authorities towards training and maintenance expenses of students. It will always, of course, be necessary, in view of the national need for social workers, for local education authorities to be liberal in the award of major scholarships both to students taking social science courses at universities and to students taking one year courses of professional training. We hope the Ministry of Education would be prepared to encourage local education authorities in this policy. It will also be necessary for employing authorities to grant extended periods of leave to selected officers, and to make contributions towards expenses and fees under existing schemes. The question of retention of superannuation rights will also arise.

A national staff college

1127. We have in addition recommended the immediate establishment of a national staff college for a number of purposes, including the initiation of pilot courses. We hope that the cost of this staff college, at any rate initially, would be borne by a charitable Trust. A college of this kind should be free to experiment and we hope that an adequate sum would be available for this purpose. There may also be some continuing expenditure to be met from central funds.

RESEARCH

1128. We have drawn attention to a number of subjects on which research is needed, and have recommended legislation to enable government departments and local authorities to conduct, or assist in conducting, research. The expenditure is likely to be comparatively small, but the help given by local authorities in providing facilities will be an important element in the success of such studies.

1129. To sum up, our recommendations will involve additional expenditure for local health, welfare and education authorities, even when due allowance is made for the direct and indirect economies that will be made. Up to and including the financial year 1958–59, Government grant to local authorities for their grant aided services has been based on the expenditure actually incurred by individual authorities on those services. Under the Local Government Act, 1958, and the Local Government and Miscellaneous Financial Provisions (Scotland) Act, 1958, a new system for the determination of grant to local authorities for a wide range of health, welfare, education and children's services (among others) will operate for the first time in the financial year 1959–60. There will be two principal changes as a result of the new Acts. In determining the sum total of grants the programmes of individual authorities will be taken into account; but the allocation to each authority will be based on a formula related mainly to population statistics, and not as hitherto to expenditure incurred. Secondly, grant to each authority will take the form of a block grant applicable to all the services to which the Acts apply, in place of specific grants for specific services. We are greatly concerned that, under the new system, individual authorities may not have the same incentive as previously to undertake and finance a programme of training, and of improvement and expansion in a series of services. We note that a similar concern was expressed by the Royal Commission on the Law relating to Mental Illness and Mental Deficiency. This is not a matter on which we can make recommendations, and we trust that in the event our fears may not prove justified. We feel, however, that they should be expressed. The provisional grants for the financial years 1959–60 and 1960–61 have been announced, but there will be opportunity, before grants for subsequent years are determined, to consider how far they have provided adequate incentives to local authorities to implement our recommendations, and if not whether any further steps might be taken.

Appendix A

LIST OF ORGANISATIONS AND INDIVIDUALS WHO SUBMITTED EVIDENCE

Association of Children's Officers.
*Association of County Councils in Scotland.
*Association of Directors of Welfare Services.
*Association of General and Family Caseworkers.
*Association of Municipal Corporations.
*Association of Occupational Therapists.
*Association of Psychiatric Social Workers.
*Association of Social Workers.

British Association of the Hard of Hearing.
British Epilepsy Association.
*British Medical Association.

Church of England Moral Welfare Council.
*College of Teachers of the Blind.
Confederation of Health Service Employees.
*County Councils Association.
*County Welfare Officers' Society.
†Miss M. Cunliffe, University of British Columbia School of Social Work, (formerly United Nations Consultant attached to Birmingham University).

Miss H. K. M. Darton, Social Worker, National Association for the Paralysed.
*Deaf Welfare Examination Board.
Deva Hospital Management Committee.

Education Welfare Officers' National Association.
*Miss J. L. M. Eyden, Lecturer and Tutor in Social Studies, University of Nottingham.

*Family Service Units.
Family Welfare Association.

*Miss E. M. Goldberg, Medical Research Council Social Medicine Research Unit.

*Miss Elizabeth Hunter, Tutor and Adviser in Social Studies, University of London.

*Institute of Almoners.
*Institute of Home Help Organisers.
*Institute of Social Welfare.
Institute of Welfare Officers.
*Inter-Regional Committee of the Regional Associations for the Blind of England and Wales and the Scottish Federation for the Blind.
*Invalid Children's Aid Association (in association with the National Association for Mental Health).

*Joint University Council for Social and Public Administration.

Mr. Frank Knight, Warden of Educational Boarding Home for Maladjusted Children.

*Liverpool Personal Service Society.
*Miss A. K. Lloyd, Senior Tutor in Social Studies, University of Durham.
Mr. A. V. S. Lochhead, Lecturer and Tutor in Social Science, University College, Cardiff.
*London County Council.
London County Council Staff Association.

Mrs. K. McDougall, Lecturer in charge of Mental Health Course, London School of Economics. Joint Editor of *Case Conference*.
Manchester and Salford Council of Social Service.
Mental Hospital Matrons' Association.
Moral Welfare Workers' Association.

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* These witnesses gave oral evidence in support of written memoranda.
† These witnesses gave oral evidence only.

National Association of Chief Male Nurses.
*National Association of Home Teachers of the Blind of England and Wales.
*National Association of Local Government Health and Welfare Officers.
*National Association for Mental Health.
National Association for the Prevention of Tuberculosis, Medico-Social Section.
*National Council of Family Casework Agencies.
*National Council of Missioners and Welfare Officers to the Deaf.
National Council of Social Service.
National Federation of the Blind of the United Kingdom.
National Institute for the Deaf.
National Institute of Houseworkers.
North-Western Group of the Association of Public Health Lay Administrators.
Mr. Russell S. Reeve, Past President of the National Association of Local Government Health and Welfare Officers.
Royal Association in Aid of the Deaf and Dumb.
*Royal College of Nursing.
*Royal Medico-Psychological Association.
Royal National Institute for the Blind.
Royal Society of Health.
†Mrs. K. de Schweinitz, Senior Fulbright Fellow.
*Scottish Counties of Cities Association.
Scottish Health Visitors' Association.
*Scottish Welfare Officers' Association.
Senior Officers of the County Associations' Committee of the Central Council for the Care of Cripples.
Society of Chief Administrative Mental Health Officers.
Society of Housing Managers.
*Society of Medical Officers of Health.
*Society of Medical Officers of Health (Scottish Branch).
*Society of Mental Welfare Officers.
Southampton Association of Social Workers.
*Standing Conference of Representatives of Health Visitor Training Centres.
Tavistock Clinic (Department for Children and Parents).
*Dr. A. J. Willcocks, Lecturer, Social Science Department, University of Nottingham.
*Mrs. J. F. Wilson, Department of Public Health and Social Medicine, University of Glasgow.
Wiltshire County Council.
*Women Public Health Officers' Association.

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* These witnesses gave oral evidence in support of written memoranda.
† These witnesses gave oral evidence only.

Appendix B

QUESTIONNAIRE TO LOCAL AUTHORITIES

(1) The Working Party's terms of reference are to inquire into:—

> " the proper field of work and the recruitment and training of social workers at all levels in the local authorities' health and welfare services under the National Health Service and National Assistance Acts, and in particular whether there is a place for a general purpose social worker with an in-service training as a basic grade."

The Working Party is not concerned with all officers employed in local authority health and welfare services: only those with social work functions as expanded in (2) below are being considered.

(2) It is not easy to define ' social work ' or ' social workers '. In a broad general sense doctors, teachers, nurses, health visitors and others are all engaged in social work since there is a social content in their activities. It is, however, desirable to restrict the term to a more precise meaning in order to avoid confusion. Thus for the Working Party's purpose the social worker is someone whose primary function is to give direct help to individuals or groups with social or personal problems which they are not able to meet satisfactorily without such help. This will include the provision of services as well as personal support based upon an understanding of the human needs of people in distress, together with some skill in rendering this kind of service. The social worker's assistance will range from straightforward advice as to how to take advantage of a particular social service to skilled help with personal problems rendered by a professionally qualified social worker. For the purpose of this inquiry the Working Party would say that:—

> The technique of sound social work consists of developing a relationship with the people concerned, diagnosing their problems, and helping them to meet their difficulties.

It will be recognised that a few residential appointments might well be held to fall within the foregoing description. For example a worker in a hostel designed for persons discharged from a mental hospital might be primarily concerned with the personal and social adjustment of the residents. Some residential posts may therefore be included if it is considered appropriate to do so.

It will be appreciated that the Working Party is endeavouring to arrive at some estimate of the number and nature of social work posts in the existing health and welfare services, whether or not those who hold them are trained social workers. Some may be qualified by experience only, others may hold another professional qualification but may occupy a social work post: for example, an occupational therapist may be employed for social welfare purposes as well as for occupational therapy.

(3) The questionnaire should be read and answered in the light of the foregoing paragraphs. Health visitors, as such, have been made the subject of a separate inquiry, and are excluded unless specifically employed to perform a social work function: and medical officers, home nurses, midwives, officers engaged in the ambulance services and home helps (as distinct from their organisers) are *outside* the scope of the terms of reference.

(4) The questions fall into 4 groups:

I. *Administrative structure of the health and welfare services*

II. *Staffing of services*

> The two tables in Part II will provide information as to how the services with a social work content are at present staffed and the qualifications, status and salary grades of existing staff. Information on current practice in regard to the employment of married women and part-time workers will be helpful in considering sources of recruitment.

III. *Post-entry training*

IV. *Information to the public and to workers in allied services*

It is appreciated that the headings under which information is desired in Parts III and IV will not all be appropriate to any one authority. Those in Part III have been listed as an indication of certain methods used in post-entry training and it will be helpful to know the extent to which any of them are currently used. It would be generally agreed that an essential part of an efficient service is informed and early use by the general public, and Part IV seeks information as to ways in which the public is kept informed of the services available.

(5) Where possible a direct answer of " Yes " or " No " should be given. Where this is not possible (e.g. question I, 2) a short statement should be given in the space provided, or, if there is not room, on a separate sheet, headed with the name of the authority and the number of the question. Authorities are asked to amplify such statements as they wish, in order to bring to the notice of the Working Party matters that appear likely to be of special interest. More detailed guidance is given in the enclosed notes (WPSW (56) 40B), which should be consulted as each question is answered.

(6) The answers to all questions should give the facts *as at* 1*st May*, 1956.

(7) For the convenience of local authorities five copies of this document are enclosed, of which two should be returned, signed by the Clerk of the Council. The Working Party would be grateful if they could be returned to reach them *not later than* 1*st October*, 1956.

July, 1956.

Name of Authority..... County Council/County Borough Council/Town Council

Population.....

QUESTIONNAIRE

I. ADMINISTRATIVE STRUCTURE

1. *Committee arrangements*

(*a*) Are the welfare services administered by

(i) a separate welfare committee? ... ...

(ii) the health committee? ... ...

(iii) a joint health and welfare committee? ... ...

(*b*) If (ii) or (iii) is there a separate welfare sub-committee? ... .

(*c*) Is there a mental health sub-committee? ... ...

(*d*) If existing arrangements are not covered by (*a*), (*b*) and (*c*) above, please give details.

(*e*) If any change in the administrative structure set out above has been decided upon but not implemented please give details.

2. *Local operation of health and welfare services*

Describe the arrangements for operating the health and welfare services locally, under the following general headings.

(i) Geographical sub-division of the authority's area.

(ii) Functions of the local offices serving these sub-divisions.

(iii) Extent of delegation of administrative responsibility to local offices.

(iv) Relationship of local offices with (*a*) statutory and voluntary agencies locally, (*b*) the public locally.

3. *Relationship with voluntary organisations*

(*a*) Are voluntary organisations employed as agents under

(i) National Health Service Acts? ... ...

(ii) National Assistance Acts? ... ...

(*b*) Give details of the ways in which, and the extent to which, the authority for the purpose of its statutory functions under the National Health Service and National Assistance Acts, assists or co-operates with or makes use of the services of voluntary bodies, without employing them as agents.

4. *Officers responsible for welfare services under National Assistance Act*, 1948

(*a*) (i) Which officer (e.g. Chief Welfare Officer, Medical Officer of Health, etc.) is responsible to the Council for the welfare services? ... ...

(ii) Please state qualifications ... ...

(*b*) (i) What other officer if any is responsible for the day-to-day administration of these services? ... ...

(ii) Please state qualifications ... ...

5. *Arrangements for co-ordination*

(*a*) Is there a Co-ordinating Committee whose functions include the co-ordination of services *other than those covered by Circular* 78/50 (*in Scotland SHD.* 749?)? ... ...

If so (i) does it deal with

(1) prevention of break-up of families (Circular 27/54, in Scotland DHS 77/54)? ... ...

(2) the aged? ... ...

(3) the handicapped? ... ...

(4) families in temporary accommodation? ... .

(5) families in danger of eviction? ... ...

(ii) how often does it meet? ... ...

(iii) who is the chairman? ... ...

(iv) does it include, as *regular* members

(1) members of the local authority? ... ...

(2) senior officers? ... ...

(3) field workers? ... ...

(4) representatives of voluntary organisations? ... .

(5) any others? ... ...

(v) Give any other relevant information on structure or constitution of committee.

(*b*) If there are any other arrangements for co-ordination, give details.

6. *Case conferences*

(*a*) Are planned case conferences held on individual cases (other than under Circular 78/50, SHD 7497) in which officers of health and/or welfare departments participate? ... ...

(*b*) If so, are they

(i) held at regular intervals? ... ...

(ii) convened only as required? ... ...

(iii) held at regular intervals and also convened as required? .....

(*c*) Has it proved possible at such conferences to arrange for subsequent visiting to be undertaken by one worker? ... ...

(*d*) Are the conferences attended by

(i) senior officers? ... ...

(ii) field workers? ... ...

(iii) representatives of voluntary organisations? ... ...

(iv) any one else? ... ...

7. *Shared services*

Give details where the services of any field worker for health and/or welfare services are shared between more than one local authority department, or between a local authority department and another statutory body (such as a regional hospital board), or a voluntary organisation.

8. *Arrangements for contacts between field workers and others*

Do workers who have direct dealings with clients usually get into personal touch with others

(*a*) in the same department

(i) direct? ... ... H..... W.....

(ii) through a supervisory officer? ... ... H..... W.....

(iii) through the chief officer of the department? H..... W.....

(iv) by any other arrangement? ... ... H..... W.....

(*b*) in other departments of the authority

(i) direct? ... ... H..... W.....

(ii) through supervisory officers? ... ... H..... W.....

(iii) through the chief officer of the department? H..... W.....

(iv) by any other arrangement? ... ... H..... W.....

(*c*) in other statutory or voluntary bodies

(i) direct? ... ... H..... W.....

(ii) through supervisory officers? ... ... H..... W.....

(iii) through the chief officer of the department? H..... W.....

(iv) by any other arrangement? ... ... H..... W.....

9. *Facilities for field workers*

Do all field workers employed by the authority in its health and welfare services have

(*a*) regular clerical assistance? ... ... H..... W.....

(*b*) official transport (or subsidised use of own car) if required? ... ... H..... W.....

(*c*) telephone facilities in their office? ... ... H..... W.....

(*d*) use of a room in which interviews can be held in privacy? ... ... H..... W.....

10. *Emergencies outside office hours*

What are the arrangements for meeting urgent needs which arise outside office hours?

II. STAFFING OF SERVICES

TABLE I

1. Statutory powers and services	2. Designation of officers performing social work functions, who are employed		
	(*a*) by local authority		(*b*) by voluntary bodies under agency arrangements (if known)
	(i) primarily as social workers	(ii) with a social work function subsidiary to their main employment	

Note—Since the space needed will vary the table is provided as a proforma to be reproduced by authorities to meet their requirements.

Table I is designed to show the *type* of officer, including administrative officers, employed by the authority or its agents to perform a social work function in the health and welfare services as indicated below. It is not concerned with individual officers, and *only their designation* (e.g. administrative assistant, almoner, welfare officer etc.) should be entered.

Health visitors are excluded, unless specifically employed to perform a social work function. Home nurses, midwives and clerical staff employed only on clerical duties should not be entered.

COLUMN 1 Statutory powers and services

The powers and services should be entered in the order shown on the next page.

In order to show the type of officer employed in each service subheadings should be entered, as indicated, under the appropriate Sections. The subheadings listed are not necessarily exhaustive, and other services may be distinguished in this way as appears appropriate.

In addition services connected with mental illness and mental deficiency should be treated separately as indicated below: as should services provided under the departmental circulars listed.

Services provided under Section 23-27 of the National Health Service Act, 1946 should not be entered.

NATIONAL HEALTH SERVICE ACT, 1946
NATIONAL HEALTH SERVICE (SCOTLAND) ACT, 1947

Section 21 ... ... *Health Centres.*

Section 22 ... ... *Care of mothers and young children.*
Distinguish unmarried mothers, mother and baby homes, and other services as required.

Section 28 ... ... (*Scottish Act, Section* 27)	*Prevention of illness care and after-care.* Distinguish T.B. and V.D. from other services. Services under Circular 27/54 (in Scotland DHS 77/54), and under the Lunacy and Mental Treatment Acts and the Mental Deficiency Acts should be entered below as indicated.
Section 29 ... ... (*Scottish Act, Section* 28)	*Provision of domestic help.* Distinguish night attendance if provided.
Circular 27/54 ... ... (*in Scotland DHS* 77/54)	*Prevention of break-up of families.*

THE LUNACY AND MENTAL TREATMENT ACTS, MENTAL DEFICIENCY ACTS AND THE NATIONAL HEALTH SERVICE ACT, SECTION 28 (IN SCOTLAND SECTION 27)

Distinguish certification procedure, other services connected with mental illness, and services connected with mental deficiency.

Circular 5/52	*Short term care of mental defectives in case of urgency.*

THE NATIONAL ASSISTANCE ACT, 1948, AS AMENDED BY THE NATIONAL ASSISTANCE (AMENDMENT) ACT, 1951

Section 21(*a*)	*Residential accommodation.*
21(*b*)	*Temporary accommodation.*
Section 29	*Welfare services for the handicapped.* Distinguish (1) blind and partially sighted, (2) deaf and dumb, (3) general classes.
Sections 37–41	*Registration and inspection of homes for the aged or disabled.*
Section 47	*Removal of persons in need of care and attention.*
Section 48	*Temporary protection of property of persons admitted to hospitals, etc.*
Section 31 *and under Circular* 11/50 (*in Scotland DHS* 65/49) ...	*Welfare of old people.*

COLUMN 2(*a*) *Designation of officers employed by local authority*

Enter the designation of the officers employed in each service distinguishing in column 2(*a*) (i) those whose primary function is social work (e.g. almoners) from those, in column 2(*a*) (ii), who perform a social work function subsidiary to their main employment (e.g. in some instances occupational therapists). Home helps, other than organisers or their deputies, should *not* be entered.

If no social work is undertaken in connection with the service enter ' None '.

Where any particular type of officer is engaged in more than one service (e.g. welfare officers) that designation should be entered opposite each such service.

Where an individual officer engaged in more than one service has two possible designations (e.g. as D.A.O. and as welfare officer) the appropriate designation should be entered opposite each such service.

Officers employed by district councils in Scotland who perform county council duties, e.g. as authorised officers, should be entered under 2(*a*) and in Table II, in both cases with an explanatory note.

COLUMN 2(*b*) *Designation of officers employed by voluntary bodies*

Enter opposite each service the designation, *if known*, of officers with social work functions employed for that service by voluntary bodies acting as the authority's agents (see question I, 3 above).

TABLE II

Designation of officer 1	Nature of duties 2	Whole or part-time 3	Sex 4	Marital status 5	Age 6	Qualifications 7	Salary 8

Note.—Since the space needed will vary, the table is provided as a proforma to be reproduced by authorities to meet their requirements.

Table II is designed to provide certain information concerning *every individual officer* covered by the entries in columns 2(*a*) (i) and (ii) of Table I. Information is not required concerning officers of voluntary organisations (column 2(*b*) of Table I).

1. *Designation of officer.* This refers to the designations given in columns 2(*a*) (i) and (ii) of Table I.

Where an officer has more than one designation in Table I, e.g. Welfare Officer and D.A.O., he should be entered in this table with a combined designation, e.g. as Welfare Officer/D.A.O.

When entries have been made for all officers with designations from column 2(*a*) (i) of Table I, draw a line across the table below these entries, and enter below the line the designations from column 2(*a*) (ii) of Table I, and the details of officers of those designations.

2. *Nature of Duties.* Enter A, S, V, R or any combination of these letters according as duties are Administrative, Supervisory, Visiting or Residential.

3. *Whole or Part-time.* Enter W or P.

4. *Sex.* Enter M or F.

5. *Marital Status.* Married or single: enter M or S. Please describe, on a separate sheet any special arrangements to enable married women with domestic ties to take up full-time or part-time work.

6. *Age.* Enter age last birthday as on 1st May, 1956.

7. *Qualifications.* So far as appropriate the following coding should be used:

A. University social science degree, certificate, or diploma acquired by full-time study with practical work.

B. University social science degree, certificate, or diploma acquired by extra-mural part-time study with practical work.

C. As B, but without practical work.

D. Full-time professional training as an almoner, or membership of the Institute of Almoners.

E. Full-time professional training as a psychiatric social worker or membership of the Association of Psychiatric Social Workers.

F. Full-time professional training as a family case-worker or membership of the Association of General and Family Case-workers.

G. Relieving Officer's Certificate.

H. Scottish Poor Law Diploma.

I. Home Teaching Certificate of College of Teachers of the Blind.

J. Diploma of Public Administration.

K. Experience as duly authorised officer (or authorised officer in Scotland).

L. More than 5 years experience in post as a social worker.

Enter for each officer the relevant qualifications from the range A–L: one or more letters to be used as appropriate.

Enter after the coded entries any other qualifications which appear relevant (e.g. examinations of the Local Government Examinations Board).

8. *Salary*. Wherever possible the salary should be expressed in terms of agreed national or professional scales, with professional grading if required to make the entry clear. Where the range covers more than one grade or scale all should be entered, to show the total range.

Where there is no agreed scale, enter the minimum and maximum of range.

Entries should be expressed in terms of full-time salaries even if the officer works only part-time.

III. POST-ENTRY TRAINING

1. Please give a brief description of any form of post-entry training currently in use, including in particular information on:—

(*a*) the way in which the training is organised and the time required;

(*b*) whether the officer's full salary is maintained throughout;

(*c*) arrangements for acquiring practical experience under guidance;

(*d*) arrangements for improving theoretical knowledge under guidance;

(*e*) planned opportunities, if any, for supervised study.

2. In which departments are any of the following available:—

(i) library service? ... ... H..... W.....

(ii) circulation of book lists? ... ... H..... W.....

(iii) circulation of periodicals? ... ... H..... W.....

(iv) regular staff meetings? ... ... H..... W.....

(v) staff bulletins?... ... ... H..... W.....

(vi) working manuals or field guides? ... ... H..... W.....

3. In addition are any of the following available or encouraged:—

(i) courses or refresher courses (organised within the service)? ... ... H..... W.....

(ii) study groups (organised within the service)? ... H..... W.....

(iii) attendance at University extra-mural classes? ... H..... W.....

(iv) attendance at other courses of various kinds? ... H..... W.....

(v) any other similar arrangements? ... ... H..... W.....

4. (*a*) Does current practice enable staff (other than in free time or annual leave):

(i) to attend conferences? ... ... H..... W.....

(ii) to attend refresher courses (not organised by the authority)

(1) resident? ... ... H..... W.....

(2) non-resident? ... ... H..... W.....

(iii) to attend study groups (not organised by the authority)? ... ... H..... W.....

(iv) to attend seminars (e.g. organised by Universities or professional bodies or United Nations)? ... H..... W.....

(v) to undertake study visits abroad, including U.N. Interchange Scheme?... ... ... H..... W.....

(*b*) Is there a study leave scheme? ... ... H..... W.....

IV. INFORMATION TO THE PUBLIC AND TO WORKERS IN ALLIED SERVICES

1. Are the public, or workers in allied services, made aware of the services available:

(i) by printed or stencilled material issued to the general public? ... ... H..... W.....

(ii) by printed or stencilled material with restricted distribution (e.g. to general practitioners, voluntary agencies or local offices of central government departments (e.g. N.A.B.))?... ... ... H..... W.....

(iii) by talks to interested groups (e.g. citizens' advice bureau staff, workers in allied services, etc.)? ... H..... W.....

(iv) in any other way (e.g. by local press)? ... ... H..... W.....

2. (*a*) Is there a focal point where members of the public can make general inquiries, e.g. information centre or inquiry officer? ... .

(*b*) If so, is this also the focal point for inquiries relating to the services dealt with in this questionnaire? ... ...

(*c*) Describe the procedure for sorting out these inquiries from general inquiries, and for referring them to the appropriate officer ...

Signed .....

Clerk of the Council

Date .....

Appendix C

GEOGRAPHICAL GROUPING OF LOCAL AUTHORITIES REPLYING TO THE QUESTIONNAIRE

1. Northern Scotland and the islands (19,280 sq. miles: estimated population 824,000)

County Councils	*Town Councils*	*Counties of Cities*
Aberdeen	Arbroath	Aberdeen
Angus[1]	Inverness	
Argyll	Perth	
Banff		
Bute		
Caithness		
Inverness		
Kincardine		
Moray and Nairn[1]		
Orkney[1]		
Perth and Kinross		
Ross and Cromarty		
Sutherland		
Zetland[1]		

2. Industrial Scotland (4,350 sq. miles: estimated population 3,838,000)

County Councils	*Town Councils*	*Counties of Cities*
Ayr	Airdrie	Dundee
Clackmannan	Ayr	Edinburgh
Dunbarton	Clydebank	Glasgow
E. Lothian	Coatbridge	
Fife	Dumbarton	
Lanark	Dunfermline	
Midlothian	Falkirk[1]	
Renfrew	Greenock	
Stirling	Hamilton	
W. Lothian	Kilmarnock	
	Kirkcaldy	
	Motherwell and Wishaw	
	Paisley	
	Port Glasgow	
	Rutherglen	
	Stirling	

3. The borders and the rural north of England (10,300 sq. miles: estimated population 1,429,000)

County Councils	*Town Councils*
Berwick	Dumfries
Dumfries	
Kirkcudbright	
Peebles[1]	
Roxburgh	
Selkirk	
Wigtown	

	County Borough Councils
Cumberland	Carlisle
Northumberland	
Westmorland	
York: N. Riding	

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4. **The industrial north** (6,760 sq. miles: estimated population 11,940,000)

County Councils	*County Borough Councils*	
Chester	Barnsley	Middlesbrough
Durham	Barrow-in-Furness	Newcastle-upon-Tyne
Lancashire	Birkenhead	Oldham
York: W. Riding	Blackburn	Preston
	Blackpool	Rochdale
	Bolton	Rotherham
	Bootle	St. Helens
	Bradford	Salford
	Burnley	Sheffield
	Bury	Southport
	Chester	South Shields
	Darlington	Stockport
	Dewsbury	Sunderland
	Doncaster	Tynemouth
	Gateshead	Wakefield
	Halifax	Wallasey
	Huddersfield	Warrington
	Leeds	West Hartlepool
	Liverpool	Wigan
	Manchester	York

5. **Eastern England** (9,170 sq. miles: estimated population 2,965,000)

County Councils	*County Borough Councils*
Bedford	Great Yarmouth
Cambridge	Grimsby
Huntingdon	Ipswich
Lincoln, parts of Holland	Kingston-upon-Hull
Lincoln, parts of Kesteven	Lincoln
Lincoln, parts of Lindsey	Norwich
Isle of Ely	
Norfolk	
Soke of Peterborough	
Suffolk, East	
Suffolk, West	
York: E. Riding	

6. **The industrial midlands** (6,580 sq. miles: estimated population 6,833,000)

County Councils	*County Borough Councils*	
Derby	Birmingham	Nottingham
Leicester	Burton-upon-Trent	Smethwick
Northampton	Coventry	Stoke-on-Trent
Nottingham	Derby	Walsall
Rutland	Dudley	West Bromwich
Stafford	Leicester	Wolverhampton
Warwick	Northampton	Worcester
Worcester		

7. **London and the home counties** (7,690 sq. miles: estimated population 13,463,000)

County Councils	*County Borough Councils*
Berkshire	Brighton
Buckingham	Canterbury
Essex	Croydon
Hertford	Eastbourne
Kent	East Ham
London	Hastings
Middlesex	Reading
Surrey	Southend-on-Sea
Sussex, East	West Ham
Sussex, West	

8. South and south west England (11,550 sq. miles: estimated population 5,021,000).

County Councils	*County Borough Councils*
Cornwall	Bath
Devon	Bournemouth
Dorset	Bristol
Gloucester	Exeter
Isle of Wight	Gloucester
Oxford	Oxford
Somerset	Plymouth
Southampton	Portsmouth
Wiltshire	Southampton

9. Rural Wales and the marches (7,680 sq. miles: estimated population 1,321,000.)

County Councils

Anglesey
Brecon
Caernarvon
Cardigan[1]
Carmarthen
Denbigh
Flint
Merioneth
Montgomery
Pembroke
Radnor[1]

Hereford
Salop

10. Industrial Wales (1,370 sq. miles: estimated population 1,634,000).

County Councils	*County Borough Councils*
Glamorgan	Cardiff
Monmouth	Merthyr Tydfil
	Newport
	Swansea

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[1] Information from these authorities related only to questions 1 and 4 of the questionnaire (administrative structure and officers responsible for welfare services). No figures have been included for them in the totals of areas and populations for each group.

Appendix D

COMMITTEE STRUCTURE AND ADMINISTRATION OF THE MENTAL HEALTH SERVICES AND OF THE WELFARE SERVICES

DECENTRALISATION OF SERVICES

1. The mental health service: mental health sub-committees

The practice of administering the mental health service by a sub-committee of the health committee is more general in England and Wales than in Scotland, where the mental health service is usually administered by the committee responsible for the welfare services, to which the necessary powers are delegated by the health committee. The position in all three countries is shown in Table 34.

Table 34: Mental health sub-committees: distribution by country, and type of authority

Type of authority	Numbers who have appointed a mental health sub-committee				Numbers who have not appointed a mental health sub-committee			
	England	Wales	Scotland	Total	England	Wales	Scotland	Total
County councils	39	5	1	45	10	6	25	41
County borough councils ...	65	2	—	67	14	2	—	16
Councils of large burghs	—	—	—	—	—	—	23	23
Total all authorities	104	7	1	112	24	8	48	80

The position in England and Wales is more fully set out in Table 35 which shows the distribution by population of the authority.

Table 35: Mental health sub-committees: distribution in England and Wales by population of authority

Population of authority	Numbers who have appointed a mental health sub-committee			Numbers who have not appointed a mental health sub-committee			Percentage of authorities with a sub-committee		
	County councils	County borough councils	Total	County councils	County borough councils	Total	County councils	County borough councils	Total
							per cent.	per cent.	per cent.
Less than 100,000 ...	5	25	30	6	8	14	45	76	68
100,000—500,000	25	36	61	7	8	15	78	82	80
Over 500,000...	14	5	19	3	—	3	82	100	86
Total ...	44	66	110	16	16	32	73	80	77

It will be seen that these arrangements are rather more frequent in county boroughs (80 per cent) than in counties (73 per cent), and are most often found in areas with a population of 100,000 and upwards.

2. The welfare services: committee structure

The committee structure of the welfare services as at 1st May, 1956, is set out in Table 36.

Table 36: Committee arrangements for the administration of the welfare services

Welfare services administered by	Numbers of authorities								
	England			Wales			Scotland		
	County councils	County borough councils	Total	County councils	County borough councils	Total	County councils	Councils of large burghs	Total
Separate welfare committee	35[1]	68[1]	103	12[1]	2	14	16	17	33
Health committee (i) without welfare sub-committee	—	1	1	—	2	2	5	1	6
(ii) with welfare sub-committee	13	8	21	1	—	1	2	—	2
Joint health and welfare committee (i) without welfare sub-committee	—	—	—	—	—	—	8	3	11
(ii) with welfare sub-committee	1	—	1	—	—	—	1	2	3
Any other arrangement	—	2	2	—	—	—	—	—	—
Total ...	49	79	128	13	4	17	32	23	55

[1] Figures include 6 English county councils, 1 Welsh county council and 3 English county borough councils where the health committee is responsible for services under Sections 29 and 30 of the National Assistance Act, 1948, and the welfare committee for other services under that Act.

3. The welfare services: patterns of administrative responsibility

The patterns of administrative responsibility in England, Wales and Scotland as at 1st May, 1956, are shown in Table 37. A distinction is made between the chief officer responsible to the council for the welfare services and the officer undertaking day-to-day responsibility for their administration, if other than the chief officer himself. In 59 per cent of all authorities responsibility to the council for the welfare services rests with a chief welfare officer who is also responsible for the day-to-day administration of the service. In 29 per cent the medical officer of health is responsible to the council and in 6 per cent the county or town clerk. In the remaining authorities this responsibility is shared either between the chief welfare officer and medical officer of health (as in 9 counties and 3 county boroughs in England) or between the clerk and the medical officer of health (as in 1 English county borough and 1 Welsh county). The majority of these authorities where responsibility is shared are those mentioned in paragraph 235 as having a welfare committee, part of whose functions (i.e., for the handicapped services) have been delegated to the health committee.

Where the medical officer of health is the officer responsible to the council, responsibility for day-to-day administration may rest with him, his medical deputy, or with a welfare officer who may or may not have chief officer status. Similarly, where the clerk is responsible for these services he may either take day-to-day responsibility himself or delegate it to a welfare officer with or without chief officer status. In the 57 authorities where the medical officer of health is responsible to the council, day-to-day responsibility is taken by a welfare officer in 45 (80 per cent), by a medical officer in 11 (19 per cent) and by the clerk of the council in 1. In the 12 authorities where the clerk is responsible to the council, day-to-day responsibility is taken by a welfare officer in 10 and by the clerk in 2.

In all, the day-to-day responsibility for the welfare services rests with either a chief welfare officer or a welfare officer in 172 authorities (86 per cent of the total), a medical officer in 11 authorities (5·5 per cent) and the clerk in 3 (1·5 per cent).

In 12 authorities (6 per cent) this responsibility is shared by a welfare officer and a medical officer, and in 2 (1 per cent) by the clerk and a medical officer.

The correlation between officers responsible for the welfare services and the committee structure in all three countries is shown in Table 38. The most frequent pattern is that in which there is a separate welfare committee with a chief welfare officer responsible both to the council and for day-to-day administration. This occurs in 54 per cent of all authorities (England and Wales 59 per cent, Scotland 37 per cent); in 46 per cent of all counties (England and Wales 52 per cent, Scotland 34 per cent), and in 60 per cent of all county boroughs and large burghs (England and Wales 64 per cent, Scotland 48 per cent). The other frequent patterns are

(1) A separate welfare committee with a medical officer of health and the welfare officer as the responsible officers. This occurs in 16 authorities (8 per cent) and is most characteristic of Scottish large burghs (26 per cent) and English and Welsh county boroughs (10 per cent).

(2) A health committee with a welfare sub-committee and the same responsible officers as in (1) above. This occurs in 17 authorities (9 per cent) and is most common in English and Welsh counties (13 per cent) and county boroughs (10 per cent).

In all three countries there is a correlation between the committee structure and the officer responsible for the services. Of 150 authorities with separate welfare committees, responsibility both to the council and for day-to-day administration rests with the chief welfare officer in 107 (71 per cent) and is shared between the chief welfare officer and the medical officer of health in 11 (8 per cent). In 19 authorities with a similar committee structure where the medical officer of health is responsible to the council, a welfare officer takes day-to-day responsibility in 16, and a medical officer in 3.

Similarly of the 33 authorities where the health committee administers the welfare services, responsibility to the council rests with the medical officer of health in 27 but in 22 of these a welfare officer takes responsibility for day-to-day administration. Where there is a joint health and welfare committee (15 authorities), the medical officer of health is responsible to the council in 10, the chief welfare officer in 4, and the clerk in 1.

Table 37: Officers responsible for the welfare services[1]

Officer responsible		England			Wales			Scotland			All 3 Countries		
(*a*) to the council	(*b*) for day-to-day administration	County councils	County borough councils	Total	County councils	County borough councils	Total	County councils	Councils of large burghs	Total	County councils	Councils of county boroughs and large burghs	Total
Chief welfare officer.	Chief welfare officer.	26	51	77	8	2	10	17	13	30	51	66	117
Medical officer of health.	Welfare officer ...	7	18	25	1	2	3	10	7	17	18	27	45
Medical officer of health.	Medical officer of health or deputy.[2]	5	1	6	1	—	1	2[2]	3	5	8	4	12
Clerk	Welfare officer ...	2	5	7	2	—	2	1	—	1	5	5	10
Clerk	Clerk	—	—	—	—	—	—	2	—	2	2	—	2
Chief welfare officer and medical officer of health (with separate responsibilities).	Chief welfare officer and medical officer of health (with separate responsibilities).	9	3	12	—	—	—	—	—	—	9	3	12
Clerk and medical officer of health. (with separate responsibilities).	Welfare officer and medical officer of health (with separate responsibilities).	—	1	1	1	—	1	—	—	—	1	1	2
Total	... ...	49	79	128	13	4	17	32	23	55	94	106	200

[1] Information from the replies to question 4 of the questionnaire, as discussed in paragraph 3.
[2] Except in one Scottish county, where the medical officer of health is responsible to the council and the clerk of the council sees to the day-to-day administration.

4. Decentralisation of services

The extent of administrative decentralisation in the health and welfare services in counties in England and Wales is shown in Table 39 (see paragraph 411).

Table 39: Decentralisation of services[1]: numbers of counties in England and Wales arranged by population and area

Population	Complete or partial decentralisation of either health or welfare services or both				No decentralisation				Total
	Area in square miles				Area in square miles				
	0–500	500–1,000	over 1,000	Total	0–500	500–1,000	over 1,000	Total	
Below 100,000	—	1	—	1	6	4	—	10	11
100,000–200,000	1	4	—	5	—	5	—	5	10
200,000–500,000	—	10	11	21	—	—	1	1	22
Over 500,000 ...	2	8	7	17	—	—	—	—	17
Total ...	3	23	18	44	6	9	1	16	60

[1] Services provided under the National Assistance Act have been treated as welfare services whether administered by the welfare committee or the health committee. Services provided by voluntary organisations acting as agents have not, however, been regarded as the authority's own services.

Table 38: Correlation between officers responsible for the welfare services and committee structure (All 3 Countries)

Officer responsible		Committee responsible for the welfare services																			
		Welfare committee			Health committee						Joint health and welfare committee						Other arrangements			Total		
					No welfare sub-committee			With welfare sub-committee			No welfare sub-committee			With welfare sub-committee								
(*a*) To the council	(*b*) For day-to-day administration	County councils	Councils of county boroughs and large burghs	Total	County councils	Councils of county boroughs and large burghs	Total	County councils	Councils of county boroughs and large burghs	Total	County councils	Councils of county boroughs and large burghs	Total	County councils	Councils of county boroughs and large burghs	Total	County councils	Councils of county boroughs and large burghs	Total	County councils	Councils of county boroughs and large burghs	Total
Chief welfare officer	Chief welfare officer	43	64	107	3	—	3	3	—	3	2	2	4	—	—	—	—	—	—	51	66	117
Medical officer of health	Welfare officer	3	13	16	2	3	5	9	8	17	4	1	5	—	1	1	—	1	1	18	27	45
Medical officer of health	Medical officer of health or deputy[1]	1	2	3	—	1	1	4	—	4	1[1]	—	1	2	1	3	—	—	—	8	4	12
Clerk...	Welfare officer	4	5	9	—	—	—	—	—	—	1	—	1	—	—	—	—	—	—	5	5	10
Clerk...	Clerk	2	—	2	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	2	—	2
Chief welfare officer and medical officer of health	Chief welfare officer and medical officer of health...	9	2	11	—	—	—	—	—	—	—	—	—	—	—	—	—	1	1	9	3	12
Clerk and medical officer of health	Clerk and medical officer of health	1	1	2	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	1	2
	Total	63	87	150	5	4	9	16	8	24	8	3	11	2	2	4	—	2	2	94	106	200

[1] Except in one Scottish county, where the medical officer of health is responsible to the council and the clerk of the council sees to the day-to-day administration.

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Appendix E

STAFFING OF SERVICES, SALARIES AND CONDITIONS OF WORK

I. STAFFING STATISTICS

Table 40: Numbers of officers of various designations

Designation of officers	All 3 countries			England			Wales			Scotland		
	Total	Counties	County boroughs, large burghs	Total	Counties	County boroughs	Total	Counties	County boroughs	Total	Counties	Large burghs
1 (*a*) Clerks responsible for the administration of the welfare services, either to the council or for day-to-day administration or both	14	7	7	8	1	7	3	3	—	3	3	—
1 (*b*) Medical officers responsible as above ...	68	31	37	41	17	24	3	2	1	24	12	12
1 (*c*) Welfare officers responsible as above ...	246	112	134	186	75	111	17	14	3	43	23	20
2 Welfare officers/mental welfare officers...	1,619	1,002	617	1,331	789	542	83	71	12	205	142	63
3 Administrative officers, with some social work functions	209	99	110	167	81	86	17	15	2	25	3	22
4 Workers with the blind	601	397	204	537	357	180	50	38	12	14	2	12
5 Workers with the deaf	8	2	6	7	1	6	1	1	—	—	—	—
6 Workers with general classes of the handicapped												
(*a*) Home visitors	87	44	43	66	27	39	16	15	1	5	2	3
(*b*) Occupational therapists and craft instructors[1]	132	89	43	129	87	42	—	—	—	3	2	1
7 (*a*) Psychiatric social workers[2]	47	26	21	43	22	21	2	2	—	2	2	—
(*b*) Other social workers employed in community care	10	4	6	8	2	6	—	—	—	2	2	—
8 (*a*) Almoners[3]	70	52	18	67	51	16	1	1	—	2	—	2
(*b*) Other social workers in the after-care services	82	49	33	82	49	33	—	—	—	—	—	—
9 Workers with families including 'problem' families	15	6	9	15	6	9	—	—	—	—	—	—
10 Home help organisers and deputies[1] ...	476	331	145	438	310	128	13	10	3	25	11	14
11 Staff of residential accommodation[1] ...	336	241	95	326	232	94	8	7	1	2	2	—
12 Visitors to residential accommodation	7	6	1	7	6	1	—	—	—	—	—	—
13 Occupation centre staff[1]...	133	65	68	125	57	68	8	8	—	—	—	—

[1] Returns for staff so marked are known to be incomplete.
[2] Including 16 shared with hospitals or other bodies.
[3] Including 14 shared with hospitals or other bodies.

Table 41: Ages of officers

Designation of officers	Number for whom age is known	Percentage in age range				
		Under 30 years	30–39 years	40–49 years	50–59 years	60 years and over
1. Welfare officers responsible for the administration of the welfare services:						
(*a*) both to council and for day-to-day administration	118	—	9·4	34·7	37·1	18·8
(*b*) for day-to-day administration	54	5·6	7·4	51·8	27·8	7·4
(*c*) as deputy to either of above	68	—	28·0	38·1	28·0	5·9
All officers included in 1 (*a*), (*b*) and (*c*)	240	1·3	14·2	39·5	32·5	12·5
2. Welfare officers and mental welfare officers	1,561	7·5	22·2	32·5	24·6	13·2
3. Administrative officers with some social work functions	204	10·8	22·6	34·7	22·6	9·3
4. Workers with the blind	601	9·9	24·8	34·5	24·2	6·6
5. Home visitors for the handicapped	87	28·8	31·0	25·3	11·5	3·4
6. (*a*) Psychiatric social workers	34	17·7	35·3	38·2	8·8	—
(*b*) Other social workers employed in community care	9	33·3	22·3	33·3	—	11·1
7. (*a*) Almoners	68	19·1	41·2	35·3	4·4	—
(*b*) Other social workers in the after-care services	82	17·1	15·9	25·6	32·9	8·5
8. Workers with families, including 'problem' families	15	13·3	13·3	53·4	13·3	6·7
9. Home help organisers and deputies	474	5·9	25·4	38·8	27·8	2·1

Table 42: Qualifications of welfare officers, mental welfare officers and administrative officers with some social work functions

Designation of officers	Total	Number of officers		Number of officers holding qualifications as under							
		With no qualification except long service	Having some qualification apart from long service	Relieving officer's certificate	Scottish poor law diploma	Diploma in public administration	Social science degree, diploma or certificate	Local Government Examinations Board		Mental nursing qualification	Others[1]
								Administrative examination	Clerical examination		
1. Welfare officer responsible for the administration of the welfare services:											
(*a*) to council and for day-to-day administration ...	122	55	67	32	11	8	3	—	2	—	29
(*b*) for day-to-day administration	55	23	32	9	9	5	4	1	—	—	7
(*c*) as deputy to 1 (*a*) or (*b*) ...	69	30	39	17	3	10	4	2	1	—	6
TOTAL of 1 (*a*), (*b*) and (*c*) ...	246	108	138	58	23	23	11	3	3	—	42
2. (*a*) Welfare officers	349	208	141	68	12	13	19	5	6	—	23
(*b*) Welfare officers also acting as mental welfare officers	428	291	137	74	33	9	9	1	2	2	14
(*c*) Mental welfare officers ...	625	332	293	100	3	17	87	3	3	63	46
(*d*) Assistants with welfare duties	192	145	47	10	4	2	8	8	15	—	2
(*e*) Assistants without welfare duties	25	16	9	1	—	—	5	—	1	1	1
TOTAL of 2 (*a*)–(*e*)	1,619	992	627	253	52	41	128	17	27	66	86
3. Administrative officers with some social work functions	209	117	92	25	4	18	8	11	2	—	48

[1] For example: legal (solicitors, barristers, LL.B.), secretarial (A.C.C.S., F.C.C.S., A.C.I.S., etc), accountancy or academic qualification.

Table 43: Employment of men and women with special reference to part-time employment of married women

Occupation	Total	Sex not known	Men	Single women	Married, widowed, divorced women	Whole-time with local authorities	Shared with hospital, voluntary body or other local authorities	Part-time	Part-time workers analysed		
									Men	Single women	Married, widowed, divorced women
1. Chief welfare officers/welfare officers responsible for the administration of welfare services	246	—	240	5	1	244	2	—	—	—	—
2. (*a*) Welfare officers	349	—	293	39	17	346	2	1	—	—	1
(*b*) Welfare officers/mental welfare officers	428	—	405	19	4	359	58[1]	11	10	—	1
(*c*) Mental welfare officers ...	625	—	370	165	90	605	9	11	7	2	2
(*d*) Assistants	217	—	180	31	6	195	17[1]	5	4	—	1
(Total of 2 (*a*)–(*d*)) ...	(1,619)	(—)	(1,248)	(254)	(117)	(1,505)	(86)[1]	(28)	(21)	(2)	(5)
3. Administrative officers with some social work functions...	209	—	170	31	8	206	—	3	1	—	2
4. Workers with the blind... ...	601	—	79	429	93	514	80	7	2	2	3
5. Workers with the deaf	8	—	4	1	3	6	2	—	—	—	—
6. Home visitors for the handicapped...	87	—	34	39	14	83	1	3	1	—	2
7. Psychiatric social workers and other social workers employed in community care	57	9	13	20	15	35	17	5	—	—	5
8. Almoners and other social workers in the after-care services	152	—	5	110	37	120	23	9	—	4	5
9. Social workers with families ...	15	—	—	8	7	14	1	—	—	—	—
10. Home help organisers and deputies	476	—	2	196	278	452	—	24	—	2	22
Grand Total	3,470	9	1,795	1,093	573	3,179	212	79	25	10	44

[1] Includes 70 district clerks in Scotland: 53 under 2 (*b*) and 17 under 2 (*d*).

Table 44: Occupations of officers holding social science degrees, diplomas or certificates (excluding professionally trained social workers)

Occupation or group of occupations	Total number	Number with social science degrees, diplomas or certificates[1]				Percentage with a social science qualification
		A	B	C	Total	
1. Welfare officers responsible for the administration of the welfare services ...	246	1	7	3	11	4·4
2. (*a*) Welfare officers ...	349	10	1	8	19	5·4
(*b*) Welfare officers/mental welfare officers ...	428	4	3	2	9	2·1
(*c*) Mental welfare officers	625	61	12	14	87	13·9
(*d*) Assistants	217	6	1	6	13	6·0
(Total of 2 (*a*)–(*d*))	(1,619)	(81)	(17)	(30)	(128)	(7·9)
3. Administrative officers with some social work functions	209	3	1	4	8	3·8
4. Workers with the blind ...	601	3	4	2	9	1·5
5. Workers with the deaf ...	8	—	—	—	—	—
6. Home visitors for the handicapped	87	23	4	—	27	31·0
7. Social workers in community care (apart from psychiatric social workers)	10	10	—	—	10	100·0
8. Social workers in the after-care services (apart from almoners)	82	20	4	6	30	36·6
9. Workers with families, including 'problem' families	15	4	—	—	4	26·7
10. Home help organisers and deputies	476	14	5	5	24	5·0
Total	3,353	159	42	50	251	7·5

[1] A distinction is drawn here between qualifications gained (A) by full-time study with practical work, (B) by extramural part-time study with practical work and (C) by extramural part-time study without practical work.

II. SALARY SCALES

Table 45: Salary maxima

Designation of officers	Number for whom information given	Percentage of officers with salary maxima of											Number of officers with salary maxima of	
		Under £500	£500–£599	£600–£699	£700–£799	£800–£899	£900–£999	£1,000–£1,499	£1,500–£1,999	£2,000 or over	Under £1,000	£1,000 or over	Under £1,000	£1,000 or over
1. Welfare officers responsible for administration of the welfare services:—														
(*a*) both to council and for day-to-day administration ...	117	—	—	0·9	4·3	6·0	12·0	36·7	25·6	14·5	23·2	76·8	27	90
(*b*) for day-to-day administration only	54	—	—	9·3	18·5	16·7	11·1	37·0	7·4	—	55·6	44·4	30	24
(*c*) as deputy to either of above	68	—	—	8·8	13·2	17·7	19·1	32·3	7·4	1·5	58·8	41·2	40	28
All officers included in 1 (*a*), (*b*) and (*c*)	239	—	—	5·0	10·0	11·7	13·8	35·7	16·3	7·5	40·5	59·5	97	142
2. Welfare officers	342	0·9	8·8	51·2	22·7	11·7	4·1	0·6	—	—	99·4	0·6	340	2
3. Welfare officers also acting as mental welfare officers	398	1·0	4·5	5·5	71·9	11·3	4·0	1·8	—	—	98·2	1·8	391	7
4. Mental welfare officers	602	0·3	3·0	28·5	54·8	7·3	5·1	1·0	—	—	99·0	1·0	596	6
5. Assistants	203	5·4	27·6	58·5	8·5	—	—	—	—	—	100·0	—	203	—
All officers included in 2–5 above	1,545	1·3	7·9	31·6	45·9	8·4	3·9	1·0	—	—	99·0	1·0	1,530	15
6. Administrative officers with some social work functions	205	4·9	14·6	24·4	19·0	18·1	10·7	5·9	2·4	—	91·7	8·3	188	17
7. Workers with the blind	595	3·5	3·7	89·8	1·7	0·5	0·3	0·5	—	—	99·5	0·5	592	3
8. Workers with the deaf	8	—	—	50·0	12·5	37·5	—	—	—	—	100·0	—	8	—
9. Home visitors for the handicapped	70	4·3	21·4	64·3	4·3	4·3	—	1·4	—	—	98·6	1·4	69	1
10. Psychiatric social workers	42	—	—	9·5	81·0	7·1	—	2·4	—	—	97·6	2·4	41	1
11. Other social workers employed in community care	10	—	—	90·0	10·0	—	—	—	—	—	100·0	—	10	—
12. Almoners	69	—	26·2	55·0	17·4	1·4	—	—	—	—	100·0	—	69	—
13. Other social workers in the after-care services	72	11·1	6·9	47·3	33·3	—	1·4	—	—	—	100·0	—	72	—
14. Social workers with families ...	12	—	33·3	58·4	8·3	—	—	—	—	—	100·0	—	12	—
15. Home help organisers	179	6·7	13·4	56·4	21·2	2·3	—	—	—	—	100·0	—	179	—
16. Deputy home help organisers ...	287	18·1	30·7	52·2	—	—	—	—	—	—	100·0	—	287	—

1. Joint Negotiating Committee for Chief Officers of Local Authorities

Chief officer scales

There are nine scales (A to I) with maxima ranging from £1,380–£2,340 per annum: salaries above this level are at the discretion of employing authorities.

2. National Joint Council for Local Authorities' Administrative, Professional, Technical and Clerical Services: scales applying in England and Wales

Table 46: Salary scales: administrative, professional and technical division (England and Wales)

Scales at 31st December, 1957		Scales at 1st May, 1956	
Grade	Salary	Grade	Salary
I	£575–£725	I ... ... II	£530–£610 £595–£675
II	£725–£845	III	£640–£765
III	£845–£985 –£1,025	IV ... ... V	£710–£885 £795–£970
IV	£1,025–£1,175	VI	£880–£1,080
V	£1,175–£1,325	VII	£975–£1,200

The National Council in their Scheme of Conditions of Service have published a number of decisions on the A.P.T. grading of certain specialist and technical staff, including some which refer to officers with a social work function.

Home teachers of the blind: A.P.T.I currently (and in 1956).

Social welfare officers:

Duly authorised officers—with or without welfare duties, A.P.T.II currently (A.P.T.III in 1956)

Welfare officers, A.P.T.I currently (A.P.T.II in 1956)

The grading of posts beyond these levels is left to employing authorities, due regard being paid to the duties and responsibilities of each post and to the standard of grading set out above.

Mental health workers

Mental health workers who are regularly responsible for performing the duties of duly authorised officer, and who also have supervisory duties in mental health or general welfare work, A.P.T.II currently (A.P.T.III in 1956).

Mental health workers employed on field duties in connection with mental deficiency or care and after-care of the mentally ill below this level, and either holding a university diploma or certificate in social science or mental health, or with not less than five years in responsible mental health social work on 1st April, 1950, A.P.T.I currently (A.P.T.II in 1956).

In the case of mental health workers who are not qualified either by academic qualification or experience, the employing authority shall determine the remuneration, due regard being paid to the standard determined for qualified workers.

The grading of senior administrative posts in the mental health service to be left to employing authorities, due regard to be paid to the duties and responsibilities of each post and to the foregoing standard of training.

Superintendents and matrons of residential accommodation provided under the National Assistance Act

Salary scales (at 31st December, 1957) for superintendents (rounded to the nearest £1) range from £389–£426 for the smallest homes to £783–£860 for the largest (scales in 1956, £345–£440 to £730–£805). The equivalent figures for matrons are £358–£450 to £594–£676 (in 1956, £315–£405 to £545–£625).

In addition to these scales emoluments are valued for superannuation purposes at from £225 10s. 0d. to £249 1s. 6d. according to the point on the scale. The equivalent range on 1st May, 1956 was £220–£243.

General, higher general, and clerical division

The scales for men are tabulated below. At present there is a differentiation between men and women which is being progressively reduced and will disappear on 1st January, 1961. The figures in brackets show extensions to the scales, which may be approved in individual instances by the National Joint Council.

Table 47: Salary scales: general, higher general, and clerical division

	Scales at 31st December, 1957	Scales at 1st May, 1956
General	£200–£450 (£490)	£180–£420 (£465)
Higher general	£230–£560 (£620)	£180–£500 (£575)
Clerical	£565–£820	£520–£770

Miscellaneous classes of officers

Salaries (at 31st December, 1957) range from £405–£725, (range in 1956, £365–£670).

3. National Joint (Industrial) Councils for Local Authority Services (Scotland)

Table 48: Salary scales: administrative, professional and technical division (Scotland)

Grade	Scales at 31st December, 1957	Scales at 1st May, 1956
I	£595–£640	£550–£595
II	£625–£670	£580–£625
III	£665–£715	£620–£665
IV	£705–£750	£655–£700
V	£765–£820	£710–£760
V (*a*)	£805–£865	£745–£805
VI	£865–£935	£805–£870
VII	£920–£1,000	£850–£925
VIII	£975–£1,055	£905–£980

Salaries (at 31st December, 1957) for the clerical, supervisory, etc. division range from £160–£295 for juveniles aged 15–20 years to £330–£820 for adults. In each case the top salaries are open to men and women, but the minima for men are £190 (juveniles) and £375 (adults). The range on 1st May, 1956, for all these divisions was £145–£275 (juveniles) and £305–£670 (adults). Since that date (inclusive) the general and higher divisions have been included in the clerical, supervisory etc. division.

4. London County Council scales for social workers

Table 49: London County Council scales for social workers

Grade	Scales at 31st December, 1957	Scales at 1st May, 1956
I	£557 10s.—£705	£528 10s.–£669 15s.
IA	—	£528 15s.–£705
II	£592 10s.–£792 10s.	£599 5s.–£775 10s.
III	£630–£927 10s.	£705–£881 5s.
IV	£815–£1,140	£775 10s.–£987
V	£1,075–£1,332 10s.	£775 10s.–£1,185 14s.
VI	£1,275–£1,482 10s.	£987–£1,184 8s.

Grading of selected special classes of officer (London County Council)

Home visitor and teacher of the blind and assistant placement officer for blind:—grade II currently (grade I in 1956).

Welfare officer for the homeless, local tuberculosis care organiser, welfare officer (V.D.) and assistant local organiser (mental deficiency supervision):—grade II currently (grade IA in 1956).

Assistant mental welfare officer (duly authorised officer), and senior assistant local organiser (mental deficiency supervision):—grade III currently (grade II in 1956).

Branch secretary (welfare of the blind), and inspector (mental deficiency acts):—grade III currently (and in 1956).

Principal tuberculosis care organiser, mental welfare officer (duly authorised officer), local organiser (mental deficiency supervision):—grade IV currently (and in 1956).

Senior organiser, mental deficiency service:—grade V currently (grade IV in 1956).

Supervisor (welfare of the blind):—grade IV currently (grade V in 1956).

Senior mental welfare officer (duly authorised officer):—grade V currently (grade VI in 1956).

5. Whitley Council Professional and Technical Council " A " Scales

(a) *Psychiatric social workers*[1]

The salary scale for a qualified psychiatric social worker is (at 31st December, 1957) £585–£810 (in 1956, £495–£750). The highest scale for psychiatric social workers with administrative or teaching responsibility is £700–£925 (in 1956, £645–£850). A research allowance of up to £75 per annum may be payable to a psychiatric social worker engaged in an organised research project involving a substantial degree of original work.

(b) *Social workers employed in psychiatric departments and clinics*[1]

At 31st December, 1957 the lowest salary scale is £495–£755 (in 1956, £420–£555) and the highest £565–£765 (in 1956, £475–£645).

(c) *Almoners*[2]

The salary for a qualified almoner is (at 31st December, 1957) £505–£605 (in 1956, £435–£535). Salary scales increase with responsibility, and almoners in charge of 10 or more almoners are paid on the scale £740–£920 (in 1956, £700–£850).

(d) *Almoners* (unqualified)[2]

At 31st December, 1957 the lowest salary scale is £410–£560 (in 1956, £360–£480), and the highest £485–£715 (previously £425–£560).

[1] The scales for psychiatric social workers and social workers employed in psychiatric departments and clinics were revised as from 1st November, 1958.
[2] The scales for almoners were revised as from 1st January, 1959.

Table 50: Details of case loads of 10 district welfare officers (Areas partly urban and partly rural)

Number of handicapped persons (General classes)	Mental Deficiency	Mental Illness		
	Number of defectives on visiting list 31st December, 1956	Hospital admissions in 1956	Hospital patients referred for after-care in 1956	Number receiving after-care visits at 31st December, 1956
65	89	29	—	2
118	238	59	8	9
56	85	77	—	6
19	92	34	13	3
62	168	38	7	7
45	116	52	11	5
51	132	24	1	2
71	138	39	6	4
181	218	77	38	12
55	102	26	—	5
723	1,378	455	84	55

Table 51: Visits and interviews by 10 district welfare officers, April–June, 1956

Purpose	Number of interviews or visits		Total
	At office	Elsewhere	
Applications for residential accommodation ...	113	226	339
Applications for temporary accommodation ...	25	28	53
Welfare of physically handicapped	47	271	318
Old people's clubs and welfare committees ...	34	150	184
Collection of charges	36	187	223
Civil defence...	9	8	17
Other inquiries	331	312	643
Total	595	1,182	1,777

Appendix F

CO-ORDINATING ARRANGEMENTS

Table 52: Number of authorities with various types of co-ordinating arrangements

Co-ordinating arrangements	England		Wales		Scotland		Total	
	County councils	County borough councils	County councils	County borough councils	County councils	Councils of large burghs	County councils	Councils of county boroughs and large burghs
Designated officer and co-ordinating committee(s), area committees or local case conferences	31	56	11	2	17[1]	16	59	74
Designated officer only: no co-ordinating committee(s) or case conferences	8	4	—	2	10	3	18	9
Co-ordinating committee(s) or case conferences only: no designated officer	7	10	1	—	—	—	8	10
No appointment and no committee(s) or case conferences ...	3	9	1	—	4	5	8	14
Total	49	79	13	4	31	24	93	107

[1] Including three councils with a designated officer in common.

The co-ordinating arrangements of the 42 county councils and the 58 county boroughs with designated officers and co-ordinating committee(s), area committees or local case conferences are further analysed in Table 53.

Table 53: Number of authorities (England and Wales) with and without area committees

Co-ordinating committee arrangements	England		Wales		England and Wales	
	County councils	County borough councils	County councils	County borough councils	County councils	County borough councils
Main co-ordinating committee(s) only	7[1]	37	6	1	13	38
Main committee and area committee(s) or local case conferences	2	13	1	—	3	13
Area committee(s) or local case conferences only ...	22	6	4	1	26	7
Total	31	56	11	2	42	58

[1] Including two authorities with two main co-ordinating committees.

Table 54: Designated officers in relation to co-ordinating committee arrangements

Designated officer	Totals			England and Wales								Scotland			
	All 3 countries	England and Wales	Scotland	Main committee only		Main and area committees (or local case conferences)		Area committees(s) or local case conferences only		No committees or case conferences		Main committee, area committee(s) or local case conferences		No committees or case conferences	
				County councils	County borough councils	County councils	County borough councils	County councils	County borough councils	County councils	County borough councils	County councils	Councils of large burghs	County councils	Councils of large burghs
County or town clerk ...	28	19	9	4	5	—	—	7	—	3	—	4	4	1	—
Medical officer of health (or deputy or area medical officer of health)... ...	47	38	9	2	17	1	5	6	6	1	—	3	4	1	1
Children's officer	78	54	24	7	15	2	8	11	1	4	6	8	6	8	2
Other (e.g. chief education officer)	5	3	2	—	1	—	—	2	—	—	—	—	2	—	—
Total	158	114	44	13	38	3	13	26	7	8	6	15	16	10	3

Table 55: Percentage of authorities where there is direct contact between field workers

	(*a*) Within department		(*b*) With other departments		(*c*) Outside local authority	
	Health	Welfare	Health	Welfare	Health	Welfare
60 County councils (England and Wales)	89	90	75	67	76	75
83 County borough councils (England and Wales)...	98	98	83	95	78	90
26 County councils (Scotland) ...	54	62	38	50	38	58
23 Councils of large burghs (Scotland)	65	74	57	74	43	65
Total authorities (192)	85	87	71	77	68	78

COMMENTS OF LOCAL AUTHORITIES ON CO-ORDINATING ARRANGEMENTS

1. **Durham**

" By serving together on the Co-ordinating Committees the officers and members of the various statutory bodies and voluntary organisations have developed a much better understanding of each other's problems and difficulties, and the closer liaison which has been engendered has been for the benefit of the various families dealt with.

There has been established an excellent two way traffic between the local housing authorities and the Co-ordinating Committees for the officers of the Committees have been responsible for assisting in cases of possible eviction due to rent arrears, whilst the local housing authorities have been very sympathetic when cases for rehousing have been submitted to them.

Duplication of visiting by social workers has been considerably reduced by the Co-ordinating Officer placing the particular case in the hands of the officer most likely to obtain the desired results."

2. **Hertfordshire**

" At that time [of the issue of Ministry of Health circular 27/54] the arrangements for the co-ordination of services relating to children were working well, but the difficulty of dealing with the problem family which found its way into Part III accommodation under the National Assistance Act, 1948, with little prospect of ever getting a house of its own again was becoming of major importance, and a great deal of time was being devoted by Health Visitors in particular to preventing the break-up of such families and their entry into Part III accommodation.

A scheme was launched as an important addition to the preventive work being carried out whereby a number of district councils made houses available for accommodating and training these families for rehabilitation. It was also found that the vast majority of cases of ill-treatment or neglect of children occurred in problem families.

Eventually, however, the need was felt for a full-time specialist officer who could devote the whole of her energies to the problem family . . . Such an officer was duly appointed and took up her duties on 1st November, 1955. Her salary is paid by the Health, Welfare and Children's Committees in equal proportion. She was appointed to the staff of my [County Clerk's] department, and at the same time I was designated Co-ordinating Officer by the Health, Welfare and Children's Committees. . . .

This new officer was named " the Families' Welfare Officer ". The Council are most pleased with what she has been able to achieve in the relatively short time since her appointment. She has held meetings in various parts of the County at

which many interested officers, both of local authorities and of voluntary bodies have attended. At these meetings she has outlined what she hoped to achieve and the way she was going to do it, and appealed for their co-operation and support which has almost always been most readily given.

The Families' Welfare Officer considers all cases referred to her of families where there is a threat of break up or eviction; the cases are referred to her principally by district councils and also by Health Visitors and domiciliary nursing staff, when the cases have reached the state that those staff feel there is little or nothing more they can do to assist.

Besides the preventive side of her work, she spends much time with the families which have broken up and are in Part III accommodation, in training them for rehabilitation into the community again. Several such families have made such progress under her tuition and care that they have been given, or promised shortly, Council houses again by the District Council from whose area they originally came. The provision of individual houses for individual families is an essential part of the rehabilitative training, and a number of such houses are leased or lent to the Welfare Department for the purpose. Families in these houses are under the direct care of the Families' Welfare Officer. Generally speaking, once this officer has taken on the care of a family, all the other officers of local authorities and voluntary bodies interested in the family will cease to visit and leave the field clear for her.

This officer often holds informal case-meetings with other interested officers, but she does not have any regular meetings of a general nature. The success which this officer has already achieved with problem families, and the increasing volume of work which is being referred to her, is such that I think before long the Council will be satisfied that it calls for an extension of the service."

3. **Newcastle-upon-Tyne**

"The service is now well established and is working very well indeed. The Local Health Authority domiciliary services have been increased and particularly the domestic help service. . . . As a result of this closer liaison between the various visitors going into the same households, it has been possible to reduce the number of individual visits and to leave the case in the hands of those who can do most at the time."

4. **Nottinghamshire**

"Finally, the experience gained has enabled certain conclusions to be drawn, particularly the following:

(i) Many problems can be more effectively dealt with at field-worker level through the existing services if there is proper understanding at an early stage among the social workers concerned.

(ii) 'Top-level' action is best confined to matters of principle rather than individual cases.

(iii) The services of the comparatively few highly skilled case-workers should be carefully allocated to families where problems are deep-seated; other cases can often be dealt with through the statutory agencies.

(iv) The co-operation of the family needing help is essential to effective action. The family's right to privacy, and duty of accepting primary responsibility, must always be borne in mind."

5. **Northumberland**

"The Council are satisfied that these measures are operating satisfactorily and effectively, that they have improved the arrangements for dealing with cases of children neglected or ill-treated in their own homes by ensuring that they are dealt with by the most appropriate service and by eliminating unnecessary visiting or over-visiting of individual cases, and that they have obviated the necessity for removing children from their homes in an appreciable number of cases. They are, however, of the opinion that the best results can only be achieved when the services of a fully trained social worker are available to carry out preventive or rehabilitative work with problem or other difficult families."

6. **Reading**

" The co-ordinating Committee itself, and in particular the Co-ordinating Officer, has been greatly assisted by a group known in Reading as the Family Aid Group, which consists of a mixture of local statutory and voluntary workers. The members are without exception trained social workers who are actively engaged in family case-work of the type done by members of the Family Service Units. . . . "

7. **Salford**

" Case conferences have taken place at regular fortnightly intervals, holidays excepted, since June, 1951. About the same time a health visitor was delegated to specialise in this work. The same health visitor has held the post throughout the past five years and such success as the conference has achieved is largely due to this continuity of service and to her zeal. Most agencies represented have suffered frequent changes of personnel. The almoner convenes the conference, acts as Chairman in the absence of the Medical Officer of Health, prepares reports from information supplied by field workers, prepares and circulates case notes after each Conference, and keeps a register of all families discussed.

As in all preventive work, it is difficult to assess success. Improvement in neglectful families is seldom spectacular though in a few cases it has been so. More often workers have to be satisfied with having stabilised a family. Nevertheless it is felt that the vigilance of case-workers which has followed a conference must have prevented much physical suffering and unhappiness among children in these families. One great advantage of the meetings has been that the various officers have acquired better understanding of each other's powers and limitations and no difficulty has been experienced in persuading various visitors to withdraw from a family where too many agencies have been involved."

8. **Somerset**

" The County Children's Committee have, therefore, expressed satisfaction with the present system, though they have emphasised the need for:

(i) Early notification being made to the Co-ordinating Officer.

(ii) A speedy decision on the value of calling a meeting of Officers concerned, and

(iii) A willingness on the part of various services to agree to one worker, preferably one with case-work experience, taking on the task of working with the family."

9. **East Sussex**

" As a general comment the existence of the Co-ordinating Committees has achieved without doubt a better understanding among statutory and voluntary officers of the duties and functions of the various social services available to a family. The Committees have also achieved a reduction in the number of visitors to each home and have in some cases to a considerable degree prevented overlapping."

10. **West Ham**

" Experience has shown that the Case Conferences have proved of considerable value. A great deal of " duplicate " visiting has been avoided. In several cases, arrangements have been made to assist harassed mothers by, for example, the provision of Home Helps, this having made it unnecessary to take children into care. With the assistance of the Housing Department, it has been possible in some cases to provide alternative accommodation for families, and so make it possible to discharge children from care. Eviction of families from their homes for non-payment of rent has been avoided in some cases as a result of the persons concerned being persuaded to meet their obligations.

There is no doubt that the operation of the scheme has on many occasions made it unnecessary to take children into care, and has thus materially assisted in preventing the break-up of families. It has also reduced the anxiety felt by individual " Field " Officers dealing with these difficult families, by giving them the support and help of the Social Services as a whole."

Appendix G

Table 56: Percentage of authorities (by regions) using specified voluntary organisations

Region	Number of authorities in region	Percentage of authorities using voluntary organisations for: Mental health and mental deficiency services	Care of unmarried mothers and moral welfare	Tuberculosis after-care	The home help service	Convalescence and recuperative centres	Family case-work	Family Service Units	Prevention of cruelty to children (N.S.P.C.C. and R.S.S.P.C.C.)	Marriage guidance	Family planning	Care of the aged	Services for the blind and partially sighted	Services for the deaf	Services for the hard-of-hearing	Care of the physically handicapped (National and local organisations)	Care of epileptics	General social services[1]
1 Northern Scotland and the islands ...	14	—	36	7	—	29	—	—	14	—	—	71	100	64	—	21	—	21
2 Industrial Scotland ...	28	46	14	4	—	—	—	—	—	4	—	96	96	89	—	43	21	4
3 The borders and the rural north of England ...	12	—	42	17	—	17	—	—	25	8	8	75	100	100	17	17	8	8
4 The industrial north ...	44	27	86	36	—	25	5	14	18	5	27	82	84	91	18	52	5	9
5 Eastern England	18	33	94	39	6	6	—	—	6	—	28	72	67	78	11	67	17	—
6 The industrial midlands ...	22	27	82	32	18	9	9	14	18	9	14	86	82	91	9	64	23	18
7 London and the home counties	19	37	95	74	21	21	11	5	11	5	32	95	95	68	47	63	21	15
8 South and south west England	18	33	94	44	17	6	—	6	6	6	33	94	83	100	28	89	6	6
9 Rural Wales and the marches...	11	9	73	18	—	—	—	—	18	—	18	55	100	73	—	45	9	18
10 Industrial Wales	6	17	67	17	—	—	17	—	—	—	17	83	50	67	—	17	17	—
All Regions ...	192	27	70	31	6	13	4	6	12	4	19	83	87	85	15	52	12	10
Total number of authorities ...	192	52	134	59	12	25	7	11	23	8	36	160	167	163	28	100	24	19

[1] Including services provided by organisations such as Councils of Social Service, Rural Community Councils, Women's Institutes, British Legion and other ex-service associations, British Red Cross Society and Women's Voluntary Services, not covered by other headings.

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S.O. Code No. 32-457