TEXT FLY WITHIN THE BOOK ONLY

UNIVERSAL
LIBRARY

OU_156216

UNIVERSAL
LIBRARY

THE SOCIAL SERVICES OF MODERN ENGLAND

INTERNATIONAL LIBRARY OF SOCIOLOGY AND SOCIAL RECONSTRUCTION

Founded by Karl Mannheim

Editor: W. J. H. Sprott



A catalogue of the books available in the INTERNATIONAL LIBRARY OF SOCIOLOGY AND SOCIAL RECONSTRUCTION, and new books in preparation for the Library will be found at the end of this volume.

THE SOCIAL SERVICES OF MODERN ENGLAND

by

M. PENELOPE HALL

Lecturer in the Department of Social Science in the University of Liverpool

ROUTLEDGE & KEGAN PAUL LTD

Broadway House, 68–74 Carter Lane

London

First published in 1952
by Routledge & Kegan Paul Limited
Broadway House, 68–74 Carter Lane
London E.C.4
Printed in Great Britain
by Western Printing Services Limited
Bristol

Second edition (revised) 1953
Third edition (revised) 1955

To
MISS E. I. BLACK
Teacher, Colleague and Friend

PREFACE

DURING the closing years of the Second World War and the period of reconstruction which followed, our social services —embracing social insurance and assistance, health, housing, education, the care of old people and of deprived children—which had been expanding and developing during the previous half-century, were examined, evaluated and reconstituted. Their scope was widened to include the whole population, and the benefits provided were made more far-reaching and comprehensive. To-day their cost forms an important item in the national budget, thousands of officials and social workers are employed in administering them, and the conception of the 'Welfare State', of which they are the concrete embodiment, is a challenge to our social and political thinking. Yet surprisingly little has been written about them. As it is less than four years since the 'appointed day' (5th July 1948) on which much of our present social legislation became operative, and as since then economic and technical difficulties have resulted in delays and shortcomings, it is still rather soon for a major analysis and evaluation of the social services to be undertaken. At the same time, judging by my teaching experience, both within a university department of social science and with extra-mural students, there appears to be a real need for a book which gives a general description of the principal social services, outlines their development and considers their present functions in relation to the needs of the individuals and groups for whose benefit they were brought into being. This is the kind of book I have tried to write. It is based in the main on published material, and is intended to serve as an introduction to, and not as a substitute for, the study of Government publications and other original and specialist writings.

The scope of the book is wide, and I fully realise that each of its twenty-two chapters could have been written by a person more knowledgeable about that particular service or branch of social work than I am myself. Consequently, I am particularly grateful to my colleagues in the Universities of Liverpool and Manchester who specialise in the subjects dealt with here, and to my friends whose task it is to administer the social services I have described, for their constructive and helpful criticisms. The suggestions made

by Miss C. F. Blackburn, Miss E. K. Blackburn, Dr. D. Chapman, Mrs. J. Cole, Miss D. M. Deed, Mr. W. Duncan, Miss M. Irvine, Mrs. A. M. Pearson, Miss V. D. Pearson, Miss M. Price, Miss D. B. Read, Mr. and Mrs. B. Rodgers, Mrs. T. S. Simey, Mr. and Mrs. F. D. Weeks and Miss J. Woodward have done much to enrich and improve the work. I should also like to thank the authors and publishers who have given me permission to quote from their books and other writings. These are referred to in the text and full details are given in the bibliography at the end. In these acknowledgments I must include Messrs. Secker and Warburg Ltd., who have agreed to my using a sentence from Lewis Mumford's book *The Condition of Man* as a chapter heading; Mr. T. S. Eliot and Messrs. Faber and Faber, who have allowed me to quote from the former's poem *The Rock*, and Messrs. A. and C. Black, who have given me permission to use the quotation from Albert Schweitzer.

This book contains a good deal of material based on articles in periodicals and other writings published by voluntary and professional associations and I should like to record my thanks to the following organisations for the help I have received from their publications: The Institute of Almoners, Family Service Units, The Family Welfare Association, The National Association of Girls' Clubs and Mixed Clubs, The Society of Housing Managers, The British Medical Association, The National Association for Mental Health, the Nuffield Foundation, Political and Economic Planning, the Institute of Personnel Management, The Association of Psychiatric Social Workers, The National Council of Social Service, The Manchester and Salford Council of Social Service, and The National Council for the Unmarried Mother and her Child.

The secretarial work involved in the preparation of this book has been carried out by Miss D. Coleman and Miss B. Gilley, who have patiently dealt with its successive drafts. I am also grateful to Miss E. Eaves for reading and correcting a portion of the typescript, and to my sister Mrs. W. J. Simmons for helping to correct the proofs.

Finally, I should like to record my indebtedness to Professor T. S. Simey, without whose inspiration I should probably not have undertaken this task, and whose continued counsel and encouragement has helped me carry it through.

January 1952 M. PENELOPE HALL

CONTENTS

PREFACE *page* v

INTRODUCTION

I. THE DEVELOPMENT OF THE SOCIAL SERVICES 3

PART I. MEETING BASIC NEEDS

II. THE PROBLEM OF POVERTY 15

III. SOCIAL INSURANCE AND SOCIAL ASSISTANCE 26

IV. THE DEVELOPMENT OF THE HEALTH SERVICES 50

V. THE NATIONAL HEALTH SERVICE 62

VI. SOCIAL ASPECTS OF HOUSING AND TOWN PLANNING 82

PART II. INDIVIDUALISING THE SOCIAL SERVICES

VII. SOCIAL CASE WORK 107

VIII. ADVICE FOR THE CITIZEN 119

IX. PROBLEM FAMILIES 132

PART III. SOCIAL SERVICES FOR CHILDREN AND YOUNG PEOPLE

X. THE WELFARE OF MOTHERS AND YOUNG CHILDREN 147

XI. THE HEALTH AND WELFARE OF THE SCHOOL CHILD 168

XII. PROVISIONS FOR THE TREATMENT OF HANDICAPPED CHILDREN 177

XIII. THE CHILD DEPRIVED OF HOME CARE 190

XIV. THE YOUTH EMPLOYMENT SERVICE 203

XV. THE YOUNG WORKER 212

XVI. THE SERVICE OF YOUTH 223

CONTENTS

PART IV. THE AGED AND HANDICAPPED

XVII. THE WELFARE OF OLD PEOPLE *page* 237

XVIII. THE PERMANENTLY HANDICAPPED 248

XIX. THE MENTAL HEALTH SERVICES 257

PART V. COMMUNITY SERVICE

XX. SETTLEMENTS AND COMMUNITY CENTRES 279

XXI. CO-OPERATION IN SOCIAL SERVICE 288

XXII. THE WELFARE STATE 305

SUGGESTIONS FOR FURTHER READING AND REFERENCE 316

INDEX 328

INTRODUCTION

'In the end all our contrivances have but one object: the continued growth of human personalities and the cultivation of the best life possible.'

LEWIS MUMFORD

CHAPTER I

THE DEVELOPMENT OF THE SOCIAL SERVICES

THE terms 'social service' and 'the social services' are relatively modern, having come into general use with the multiplication of public and voluntary provisions to further the well-being of members of the community which is one of the outstanding characteristics of our times. They are terms which are sometimes used rather vaguely, and universal agreement has not yet been reached as to which services should be classified as 'social'. Some vagueness is inevitable, and may even be desirable, in a sphere in which growth and change are continually taking place, but the establishment of criteria by which the social services can be distinguished from other forms of public and voluntary effort contributing to the general good is essential if the words are to have any meaning at all.

The generally accepted hall-mark of social service is that of direct concern with the personal well-being of the individual. Thus, Mrs. Gertrude Williams, in a recent discussion of 'The Recruitment and Training of Social Workers', postulates that the essence of social work is that it involves personal relationships, and illustrates this by pointing out that although a public utility service is undoubtedly for the public benefit, the main concern of the officer in charge is 'to see that the facilities provided are adequate in amount and efficient in operation. . . . His interest is in the object provided and not in the people who make use of it.'[1] The social worker, on the other hand, is concerned not only with the efficient administration of a particular service, but with the effects of its use on the personalities and relationships of the people taking advantage of it. Social service is essentially 'the manifestation of a personal interest in a human situation',[2] a recognition both of

[1] Gertrude Williams, 'The Recruitment and Training of Social Workers', in Henry Mess and others, *Voluntary Social Services since 1918*, p. 227.

[2] The phrase is taken from a pamphlet entitled *Goodwill in a Great Society*, by Professor A. Radford, then Professor of Social Administration, University of Nottingham (National Council of Social Service, 1948, p. 12). Professor Radford uses it as a definition of voluntary social service, but it appears from the context that he is using the term 'voluntary' to describe a method of approach rather than in the usual sense of 'non-statutory'. The pamphlet is now out of print.

the uniqueness and value of the individual, and of our common humanity.

The basis of social service is then to be found in the obligation a person feels to help another in distress, which derives from the recognition that they are in some sense members one of another. This sense of community and consequent obligation may be narrowly restricted to the family, tribe or neighbourhood, and the needs of all outsiders disregarded, or it may be widened to embrace mankind itself, and lead an Albert Schweitzer to abandon a brilliant career in Europe to give medical care to the primitive people of Central Africa, or a Father Damien to devote his life to the lepers of a remote Pacific island. In its simplest form it manifests itself in neighbourly action, but, as civilisation has advanced and life become more complex, its scope has widened, and its mode of expression become more varied and elaborate. In particular, the transformation, wherever and whenever it has occurred, from an agricultural society made up of close-knit and almost self-contained family groups living in isolated local communities, each responsible for the care of its own poor and unfortunate, to a highly industrialised urban society, has necessitated a complete rethinking of the implications of the question 'Who is my neighbour?' and its answer 'He that showed mercy unto him'.

This was one of the problems which faced the people of Britain as the Agrarian and Industrial Revolutions, starting in the sixteenth century and gaining momentum until they culminated in the early nineteenth century, altered not only the face of the country but the whole structure of society, and this in such a way that neighbourhood and community life came to be at a discount. Throughout the nineteenth and early twentieth centuries statesmen, philanthropists, writers and thinkers slowly, almost reluctantly, groped their way towards the new conceptions of social welfare and social obligation which were needed to meet the changed situation. As time went on these were embodied in a network of services both statutory and voluntary which had as their object the enhancement of the well-being of the individual citizen, and these are the services which we know as the social services.[1]

The first important steps in this direction were taken in the six-

[1] The phrasing of the definition is that of Political and Economic Planning, *Report on the British Social Services*, p. 10. For further discussion of the developments outlined above see T. S. Simey, *Principles of Social Administration*, p. 4. He describes the emergence during the nineteenth century of two types of State interference in the social life of the community, one resulting in the 'environmental services' which sought to improve the individual's physical environment, the other in the establishment of 'personal' services which set out 'to provide the individual *as an individual* with the precise form of assistance he needs'. Author's italics.

teenth century. Legislation culminating in the famous Poor Law Act of 1601[1] made it the duty of the local community (the parish) to provide for those 'poor, old, blind, lame and impotent' persons in its area whose families were unable to maintain them, to set to work the able-bodied who lacked the means to maintain themselves, and apprentice or set to work the destitute children, and, until the disturbances leading to the Civil War weakened the authority of the central government, the Privy Council took pains to ensure that these responsibilities were properly carried out by local Justices and Overseers.

The relief of destitution, was, however, as far as the State went in its concern for the personal well-being of its citizens, and Poor Relief was still the only statutory social service at the time of the Industrial Revolution. At this time, too, the economic doctrine of *laissez-faire* combined with Malthusian theories of population growth to stifle all desire on the part of the governing classes to interfere with the condition of the people, except to increase the efficiency and rigidity of the Poor Law so as to ensure that only those who were in desperate need and unable to help themselves or get help in any other way could apply for or obtain relief.[2]

This indifference could not last, however. Humanitarians, of whom Lord Shaftesbury is an outstanding example, and writers, such as Charles Dickens and Mrs. Gaskell, brought the cry of the exploited factory and workhouse children to the ears of the public and to the notice of Parliament. Able administrators such as Edwin Chadwick, realised that there was a significant relationship between squalor, disease and destitution, and, backed by sanitarians such as Dr. Southwood-Smith, began a campaign for cleansing the towns in the interests of public health; while the gradual realisation of the advantages of a literate, if not necessarily an educated, working class brought a measure of public support to those such as Joseph Lancaster, and, a generation later, Sir James Kay-Shuttleworth, who had begun the long slow task of popular education.

Apart from education, the chief efforts of the social reformers of the greater part of the nineteenth century were directed to creating passable environmental conditions in factory, mine and town, and to guarding the people from infectious disease. After the close of the century, however, the State took a more active part in the creation and extension of the personal services, and the years following the triumph of the Liberal Party in 1906 saw the introduction of schemes for the feeding and medical inspection of school children, the granting of old age pensions, the setting up of labour

[1] An Act for the Relief of the Poor, 43 Eliz. c. 2.

[2] This was done by the Poor Law (Amendment) Act of 1834.

exchanges, the establishment of Trade Boards, the passing of the Probation of Offenders and the Children Acts and the introduction of a state scheme of social insurance. From then onwards progress towards a Welfare State was rapid, and to-day social services provided by the State, either directly or through the local authorities, impinge on the life of the individual from the time of his entry into the world, assisted by a municipal midwife, until his burial in a municipal cemetery, his funeral expenses met by a death grant from the National Insurance Fund.

This assumption of statutory responsibility for the well-being of the individual citizen has been accompanied by a change in the scope of the social services. In a simple society with few class distinctions 'social service' is simply the help given by a man to his neighbour in difficulty, but in a society where there are extremes of wealth and poverty it becomes 'charity' or 'philanthropy', the assistance given by the rich to the poor. Thus the division of Victorian society into Two Nations, the Rich and the Poor, was reflected in its division into Givers and Receivers. The Rich were expected to give of their wealth and their leisure, the Poor to receive these gifts gratefully, and order themselves lowly and reverently to all their betters. To-day we are moving towards a more equalitarian society, and the principal social services are provided and paid for by the community as a whole for the benefit of all its members. Thus a universal scheme of social insurance has replaced the Poor Law; hospitals are no longer places where the sick poor obtain the medical and nursing care they cannot afford to obtain privately, but centres of specialised medical treatment for all; and, whereas in 1833 the Government made a grant to the National Society for the Education of the Poor in the Principles of the Established Church, to-day there is a Minister of Education charged with the promotion of the education 'of the people of England and Wales'.[1]

There were signs of this change in the scope of the social services, with the change of outlook it implies, in the years before the Second World War, but the real change in attitude came about with the war itself. As Professor Titmuss has shown in his survey of the developments in social policy during this period, the administrators who were entrusted with making preparations to meet the social chaos likely to be caused by aerial attack were so imbued with the tradition which placed the 'poor' and the 'fortunate' in separate categories that they failed to realise that total war is no respecter of persons. Hence they made the 'fundamental error' of assuming that the relief of the victims of air raids could be administered on Poor Law principles, and much misery and confusion was

[1] Education Act, 1944. Section I (1).

caused thereby.[1] However, under the stress of bombardment, and as a result of the drawing together of all members of the community in the face of a common danger, this attitude was profoundly modified and the way prepared for transforming the social services into a nation-wide scheme of mutual assistance and care.

The two modern developments just discussed, namely the increasingly important part played by the State in the furtherance of the well-being of the individual citizen, and the increase in the scope of the social services so that they cover the whole population, have been accompanied by a significant change of outlook on the part of both their administrators and their users. Social service benefits are now regarded as among the rights of citizenship, the citizen need not be ashamed of availing himself of them, nor may the administrator withhold them on the ground that the recipient is undeserving. This change in outlook has released many from the burden of shame and guilt which intensified the misery of unavoidable poverty and dependence on statutory or voluntary assistance in the days when this meant the forfeiture of self-respect, and it was almost a crime to be poor, but over-emphasis on rights has its own dangers. The State, to quote the pre-war simile of Professor Robson, comes to be looked on as a kind of penny-in-the-slot machine, into which you put a coin and draw out a packet of chocolate[2] or even as a kind of universal provider, from which it is possible to obtain unlimited benefits without much exertion or worry. It is generally recognised that decline in initiative and repudiation of private and public responsibility are among the dangers arising from the multiplication of statutory social services, but those who laboured to create these services hoped rather that by freeing men and women from excessive anxiety and preoccupation with the struggle to obtain the bare necessities of life, they would provide them with opportunities for a more fruitful exercise of their talents and greater fullness of life.[3] The ordering of our social life so as to achieve this is one of the challenges of our times.

A further problem arising from the greatly increased scope of the social services, and associated with the assumption of statutory responsibility for them, is the danger of their mechanisation. It was stressed at the beginning of this chapter that social service is essentially personal in character, concerned with meeting the needs of the individual as such, but the social services have grown

[1] R. M. Titmuss, *Problems of Social Policy*, H.M.S.O., 1950, pp. 250–256.
[2] William A. Robson, *Social Security*, first edition 1943, second edition 1947, p. 29.
[3] Cf. Lord Beveridge, *Social Insurance and the Allied Services*, Cmd. 6404, 1942, p. 170, par. 455.

so vast and complicated that he may easily become a cipher, his needs assessed according to a formula. This tendency, together with the emphasis on 'right', has been carried furthest in the social insurance schemes, where benefits are obtained on a contractual basis, but it can be discerned in other services too, and, as Professor Radford has pointed out,[1] is not confined to the statutory services, but threatens all large organisations. It is one of the fundamental problems of the Great Society, and its manifestation in the social services can be paralleled by similar developments in industrial and other relationships. In part it is a technical or administrative problem, but it is surely not beyond the wit of man to overcome the administrative difficulties of dealing with large numbers, given the right attitude of mind. This attitude was well expressed by the Rt. Hon. Lord Soulbury, then Chairman of the Assistance Board, in a speech made at a conference convened by the National Council of Social Service in 1941. 'Welfare provisions in various statutes', he said, 'show that the State has now accepted the view that social legislation should not be confined to money payments and legal safeguards, but should seek the good life of its citizens.... The good administrator must realise that every citizen is an individual with his own life to live and particular needs to satisfy, that he is a unique thing with a spirit indestructible and imperishable, and never a mere cipher in a mass of figures.' If means can be found to give expression to this ideal in the day-to-day work of the vast army of social servants of the State, then one of the most difficult problems of the modern social services will have been solved.

It is a curious paradox that, at a time when the social services are in danger of losing their essentially personal character because of their increasing size and complexity, social service is becoming more concerned with problems of human conduct and relationship. In the past, problems of poverty, of public health, of long hours and unsatisfactory conditions of work were so pressing that to a large extent social reformers concentrated on them. The most urgent problems which confront sociologists, social administrators and workers to-day are such symptoms of a sick society as the increasing number of marriage breakdowns, the spread of juvenile delinquency, and the dissatisfaction and sense of frustration of the worker in spite of improved pay and conditions—that is, problems of psychological maladjustment rather than material need. They are problems which must be handled with great tact and delicacy, and need personal rather than mass techniques. Some students of social affairs consider that this is the point at which the voluntary organisations, with their smaller case loads and greater flexibility

[1] Op. cit., p. 10.

than the statutory services, have their special contribution to make, and the recommendations of the Denning and Harris Committees on the provision of a marriage guidance service, are examples of this type of thought.[1] But, important as is the contribution of the voluntary case work organisations, the State cannot solve its problems by handing over all cases demanding individual care to them. Some situations in which the psychological aspect is crucial, in which personal relationships are most important, and co-operation between client and worker fundamental if a readjustment between the individual and society is to be made, also necessarily involve an element of compulsion in the interests of both the individual and the community. In these cases, for example, cases of delinquency or more serious breakdowns in mental health, the State cannot abrogate its responsibility to voluntary bodies, but must itself evolve the techniques necessary to meet the situation. The shifting of the emphasis in social work from satisfying the material needs of those unable to provide for themselves to the adjustment of personal relationships, and the integration of the maladjusted individual into society, is a challenge to all concerned with the development of the social services, both statutory and voluntary. It demands from the worker not only imaginative sympathy and patience, but also wisdom and understanding, including some knowledge of the human mind and its working, and of the culture of the society of which the individual is a member.

The change of emphasis just described is one of the reasons for the increasing importance attached to the selection and training of social workers. It is now realised that in the delicate task of adjusting human relationships an insensitive or unskilled worker, however well-meaning, may do harm rather than good; and hence, although there is still room for the voluntary or untrained worker, responsible positions should be held by those who are devoting their lives to the work, and who have received special training, including both theoretical instruction and practical experience under careful supervision, designed to widen their knowledge and understanding. Some of the most important developments in social service in modern times have been in connection with the training of social workers, the emergence of the various social work professions, and their gradual recognition.

An important modern development which has profoundly affected the scope and character of the social services is the appli-

[1] Final Report of the Committee on Procedure in Matrimonial Causes, Cmd. 7024, 1947. Report of the Departmental Committee on Grants for the Development of Marriage Guidance, Cmd. 7566, 1948.

For further discussion of the Reports of these Committees see Chapter VIII, and of the role of voluntary services in the Welfare State, see Chapter XXI.

cation of scientific method to the study of social problems. The efficient and energetic disciples of the political philosopher, Jeremy Bentham, were among the first to utilise this approach, and such reports as the Report on the Sanitary Conditions of the Labouring Population, which was prepared at the request of the Poor Law Commission of which Chadwick was secretary, and published in 1842, marked a real advance in technique. The study of society began to claim a place among the sciences, and the need for an objective study of the facts of the situation as a preliminary to social action became more widely recognised. This attitude found its most important nineteenth-century expression in Charles Booth's monumental survey, *The Life and Labour of the People of London*, and the conclusions reached as a result of this survey, and the little classic which followed it—B. Seebohm Rowntree's detailed study of York, *Poverty, a Study in Town Life*—revolutionised men's ideas as to the extent and causes of poverty, and prepared the way for much of the social legislation of the first decade of the twentieth century.[1]

Booth and Rowntree set a fashion in social surveys, and during the first half of the twentieth century a number of areas were studied in this way. The surveys were usually undertaken by a university or similar disinterested body, and set out to throw as much light as possible on economic and social conditions in a particular area. In general they were confined to those aspects of social life which are most amenable to statistical treatment, and accumulated material on such objective facts as the extent and causes of poverty or overcrowding, rather than attempting to discover people's reactions to them. Much recent social research, such as that of the War-time Social Survey (now the Social Survey) and the Tavistock Institute of Human Relations, attaches increasing importance to the attitudes of people to social conditions, and relationships between individuals and groups. This type of investigation demands great tact and skill on the part of the investigator, and great care is needed in the interpretation of the data thus obtained, but in the long run the findings of these research workers may be as important in their influence on the next generation's approach to social problems and policy as the findings of Booth and Rowntree were in their day.

The development of social research is one aspect of the growth of the scientific attitude towards social questions, but this attitude also influences the whole approach of the social worker and administrator. The young social worker of to-day has to a large extent abandoned the moral judgments of his predecessors, and thinks instead in terms borrowed from medicine or psychiatry. In many

[1] See Chapter II, pp. 15–17.

respects this approach is an advance. From the patient labours of psychologists and psychiatrists social workers have gained much in increased understanding and the ability to deal sympathetically yet objectively with difficult situations and relationships, and are beginning to learn to apply to their own society the knowledge the anthropologist has gained from his study of cultures differing greatly from our own. But this increased toleration and understanding, vital as it is, does not release the social worker, nor for that matter the sociologist, from the obligation to consider the ethical values underlying his work. Rather, since increased knowledge brings increased power, it may be said to impose a greater obligation. As Karl Mannheim has pointed out, the crisis through which western civilisation is passing is essentially a crisis of valuation, and in the social, as in the natural, sciences there is always the danger that developments in technique may outstrip growth in spiritual and moral stature and ultimately result in disintegration instead of more abundant life. 'What is the good of developing child guidance, psychiatric social work, psychotherapy, if the one that is to guide is left without standards?'[1]

The more important modern developments in social service and the social services which have led up to the situation to-day are then, the increasingly active and prominent part played by the State, which has gradually assumed responsibility for meeting the basic needs of all its citizens; the widening of the scope of the social services to include the whole community, without distinction of social or economic class; the acceptance of the benefits they confer as rights; the increasing importance attached to the adjustment of relationships as well as of meeting material needs; the increased and increasing influence of the scientific attitude and the development of social research, and the growth of professionalism. The body of this book will, it is hoped, illustrate these developments and their implications in different fields. The section which follows describes the social services which have been evolved to meet man's basic material needs, that is those services which aim at the maintenance of a minimum economic standard when the family is unable to do this unaided, the provision of adequate health and medical care, and of housing accommodation which makes possible the creation of a home. But fundamental as these services are, they are insufficient in themselves, and the multiplication of services designed to raise the standard of life of the whole community has been accompanied by the development of social case work which helps the individual to overcome his personal difficulties and make constructive use of the more general services. This is described in Part II. The two following Parts deal with the efforts made by

[1] K. Mannheim, *Diagnosis of Our Time*, p. 25.

the community to meet the needs of those of its members who need special care and for whom it has a continuing responsibility, namely the children and young people, the aged, and the handicapped. The book ends with a discussion of neighbourhood work and of the development and possibilities of co-operation between the different forms of social service, and some further consideration of the more fundamental issues affecting or resulting from the assumption by the community of responsibility for the social well-being of its members.

PART ONE

MEETING BASIC NEEDS

'Really I think that the poorest he that is in England hath a life to live as the greatest he.'—THOMAS RAINBOROUGH, 1647.

'Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.'—*Universal Declaration of Human Rights*, adopted and proclaimed by the General Assembly of the United Nations on the tenth day of December 1948, Article 25.

CHAPTER II

THE PROBLEM OF POVERTY

'They that are snared and entangled in the utter lack of things needful for the body cannot set their minds on Thee as they ought to do, but when they are deprived of the things they so greatly desire, their hearts are cast down and quail for grief.'—*Prayer Book of Queen Elizabeth.*

THE complexity of modern economic and social life is matched by the elaborate ramifications of its social services, but just as the primitive needs of food, clothing and shelter remain in the most refined and mechanised society, so must the guarantee that no member of the community perish from cold or hunger for lack of succour from his fellows remain the basic obligation of the Welfare State. 'Freedom from Want' is not the same thing as social security, in the full meaning of these words, and it is unfortunate that the two are identified in the minds of many people, but the one contributes to the other, and measures to secure minimum economic standards for all families at all times are basic to any comprehensive social policy. Moreover, to be effective such measures must be based on a real understanding of the reasons why individuals and families fail to reach this standard unaided.

A great advance towards the understanding of the extent and causes of poverty resulted from the researches of Charles Booth and B. Seebohm Rowntree. The former published the first of his seventeen volumes surveying *The Life and Labour of the People of London* in 1889; the latter's detailed investigation of social conditions in York, *Poverty, a Study in Town Life*, was published in 1901. Both investigators chose as their standard of poverty a bare sufficiency of the means of livelihood, and Rowntree endeavoured to make this definition as precise as possible by working out as scientifically and objectively as he could a 'physical efficiency' standard based on the incomes required by families of different sizes to provide the minimum of food, clothing and shelter needed 'for the maintenance of merely physical health'.[1] Families whose

[1] Booth describes this standard as follows: 'By the word "poor" I mean to describe those who have a sufficiently regular though bare income, such as 18s. or 21s. a week for a moderate family, and by the "very poor" those who fall much below this standard.' Charles Booth, *Life and Labour of the People of London* Series, Vol. I, p. 33; cf. B. Seebohm Rowntree—*Poverty, a Study in Town*

income failed to reach this level were regarded as living in 'primary poverty' or below the poverty line, and a house-to-house survey made in 1899 revealed that 15·46 per cent of the wage-earners or 9·9 per cent of the total population of York were in this position—that is, the income coming into the home was so small that even if every penny were spent on physical necessities it would still be inadequate to meet the family's needs.[1] This result was strikingly similar to that obtained by Charles Booth as a result of his less precise but very comprehensive survey of East London.

The amount of primary poverty revealed by the investigations of Booth and Rowntree caused some concern, but even more disturbing to accepted beliefs were the conclusions reached by their authors as to its causes. Legislators and philanthropists of the Victorian era had emphasised the personal element in the causation of poverty. It was assumed that with hard work, thrift and sobriety a workman should be able to keep himself and his family, put by sufficient to cover periods of sickness or unemployment, and save for his old age, when in any case his children would contribute to his support. Failure to achieve and maintain this financial independence, which was regarded as the basis of self-respect, was believed to be due to exceptional misfortune, or deplorable weakness on the part of the individual or family concerned, and hence the Victorians relied on the painstaking case work of the Charity Organisation Society and kindred organisations to relieve the distress of the 'helpable' or 'deserving'[2] and consigned the remainder to the harsh mercies of a deterrent Poor Law. The investigations of

---

Life, ch. iv, pp. 86 ff. As a result of careful inquiry Rowntree suggests 21s. 8d. as the minimum necessary expenditure for physical efficiency for a family of man, wife and three children, which corresponds very closely with Booth's 18s.–21s. for a 'moderate' family. Corresponding figures for families of differing sizes are set out on p. 110 of *Poverty, a Study in Town Life*.

[1] 'And let us clearly understand what "merely physical efficiency" means. A family living on the scale allowed for in this estimate must never spend a penny on railway fare or omnibus. . . . They must write no letters to absent children, for they cannot afford to pay the postage. They must never contribute anything to their church or chapel, or give any help to a neighbour which costs money. They cannot save, nor can they join a sick club or Trade Union because they cannot pay the necessary subscriptions. The children must have no pocket money for dolls, marbles or sweets. The father must smoke no tobacco and must drink no beer. . . . Should a child fall ill it must be attended by the parish doctor, should it die, it must be buried by the parish. Finally, the wage-earner must never be absent from his work for a single day. If any of these conditions are broken the extra expenditure involved is met, *and can only be met*, by limiting the diet, or in other words by sacrificing physical efficiency.' B. S. Rowntree, *op. cit.*, pp. 133–4. Author's italics.

[2] These case work methods and the principles underlying them are described in Chapter VII, while the relationship between the voluntary organisations and the Poor Law is described in Chapter XXI.

Booth and Rowntree, supplemented a few years later by those of Professor A. L. Bowley and Mr. A. R. Burnett-Hurst in five English towns of varying size and industrial character[1] demonstrated conclusively that, while personal factors might be present, poverty in the early years of the twentieth century was due in the main to factors which were beyond the control of the individual affected. These factors were earnings so low or so irregular as to be insufficient to meet the family's needs; families so large that their needs could not be met by wages which were sufficient to keep average families above the 'poverty line'; and interruptions of earnings through sickness, unemployment, old age or premature death, which the family had not the resources to meet, as the low wages earned during employment precluded saving. At the conclusion of his 'Five Towns' survey Bowley wrote, 'Of all the causes of primary poverty which have been brought to our notice, low wages is by far the most important. To raise the wages of the worst-paid worker is the most pressing social task with which the country is confronted to-day.'[2]

This sums up the position at the end of the first decade of the twentieth century. Twenty or thirty years later the situation had altered in some important respects. The total amount of dire poverty had declined. This was shown, for example, by a second survey of York which Rowntree undertook in 1935, and which demonstrated that the number of persons living below the 'physical efficiency standard' of 1899[3] had decreased from 15·46 per cent of the working class or 9·91 per cent of the whole population of York to 6·8 per cent of the working class or 3·9 per cent of the total population of the city. This was an advance, but further investigations revealed that 31·1 per cent of the working class or 17·7 per cent of the total population of York were in receipt of incomes which, although they might reach the 'physical efficiency' level, were insufficient to reach a slightly less austere standard based on 'human needs'. This standard allowed each family an income which, in addition to paying the rent and providing a bare sufficiency of

[1] A. L. Bowley and A. R. Burnett-Hurst, *Livelihood and Poverty*, 1915. The five towns investigated were Northampton, Warrington, Stanley (a mining town in Co. Durham), Reading and Bolton.

[2] Op. cit., p. 42. Rowntree's survey of York revealed that the immediate cause of poverty was lowness of wage in 51·96 per cent of the total number of those living in primary poverty. He concludes, 'It is thus seen that the wages paid for unskilled labour in York are insufficient to provide food, shelter and clothing adequate to maintain a family of moderate size in a state of bare physical efficiency'. *Poverty, a Study of Town Life*, pp. 131 and 133.

[3] Allowances were of course made for the rise in prices during the intervening years. The equivalent of the 17s. 8d. (exclusive of rent) considered in 1899 to be adequate to meet the 'physical efficiency' requirements of a man, wife and three children was 30s. 7d. at 1936 prices.

food, clothing, warmth, light and household necessities, left a small margin to cover such items of personal expenditure as bus fares, burial clubs, tobacco, trade union subscriptions, newspapers and the wireless licence, items which although not essential for physical survival are regarded as necessary components of civilised living.[1] The results of other investigations made during the inter-war years varied slightly according to the precise standards by which human needs were assessed, the character of the area and the state of trade when the survey was made, but they were sufficiently close to demonstrate that even if standards had risen since the beginning of the century, as late as the 1930's a disquietingly large proportion of the citizens of this country were without adequate resources to meet their basic human needs.[2]

Just as Booth and Rowntree had analysed the causes of the poverty they uncovered, so the later investigators attempted to assess the contributions made by various economic and social factors to the new situation. The decline in the amount of dire poverty was attributed in the main to the increases in the wages of unskilled workers brought about by the 1914–18 war, while the declining birth-rate with its consequent reduction in the numbers of families with large numbers of young children was considered to be a contributory factor. At the same time the wages paid in some occupations were still too low to meet the needs of the wage-earner with several children to maintain, while owing to the prolonged trade depression of the inter-war years, which hit certain occupations and areas particularly hard, poverty due to the interruption of earnings, particularly as a result of unemployment, was widespread. By this time social insurance schemes were well established, but the benefits received, while they were sufficient to prevent destitution, were inadequate to meet the 'human needs' of their recipients. The situation was summed up by Sir William (now Lord) Beveridge at the beginning of his *Report on Social Insurance and the Allied Services*: 'During these years [i.e. the years immediately preceding the Second World War] impartial scientific authorities made social surveys of the conditions of life in a

[1] Rowntree has described the methods he used to arrive at his 'human needs' standard in a little book called *The Human Needs of Labour*, which was published in 1937. A man, wife and three dependent children were allowed 43s. 6d. exclusive of rent; cf. 30s. 7d. on the 'physical efficiency' standard.

[2] For example, 16 per cent of the families included in the Merseyside Survey made in 1929 were found to be living below a poverty line slightly more austere than Rowntree's 'human needs' standard; 15·4 per cent of the Sheffield working-class families surveyed in 1931–2 and 10·7 per cent of the Bristol families investigated in 1937 were similarly placed. (*Survey of Merseyside*, Vol. I, p. 153; A. D. K. Owen: *Survey of the Standard of Living in Sheffield*, p. 24; Herbert Tout: *The Standard of Living in Bristol*, p. 24.)

number of the principal towns in Britain, including London, Liverpool, Sheffield, Plymouth, Southampton, York and Bristol. They determined the proportions of people in each town whose means were below the standard assumed to be necessary for subsistence, and they analysed the extent and causes of that deficiency. From each of these social surveys the same broad result emerges. Of all the want shown by the survey, from three-quarters to five-sixths, according to the precise standard chosen for want, was due to interruption or loss of earning power. Practically the whole of the remaining one-quarter to one-sixth was due to failure to relate income during earning to the size of the family . . . abolition of want requires a double redistribution of income through social insurance and by family needs.'[1]

The need for some form of family or children's allowances to overcome the poverty caused by the failure to relate income during earning to family needs had been urged by a group of reformers, prominent among whom was Miss Eleanor Rathbone,[2] for many years before Lord Beveridge insisted that no scheme of social security would attain its end without them. Their adoption was advocated on three main grounds.

In the first place, it had long been common knowledge and experience that if wage rates remained unchanged, the wages of the unskilled labourer reached their maximum in his early manhood. Consequently, as the number of children increased the standard of living of the family tended to decline, and if wages were low to start with it was in danger of sinking below the poverty line with the coming of two or three children. This was confirmed by the findings of the social surveys. For example, Rowntree concluded as the result of his 1935 survey of York that 52·5 per cent of the working-class children under one year of age were living below the human needs standard; that 47 per cent would probably remain in poverty as defined for five years or more, and 31·5 per cent for ten years or more.[3] The results of the Bristol Survey made in 1937 were similar—10·7 per cent of the families surveyed were below the minimum standard, but these included more than 20 per cent of the children under 15, and the author comments: 'It is an appalling fact that one working-class child in every five comes from a home where the income is inadequate to provide a bare minimum standard according to the austere survey rules.' Thus it was clear that

[1] *Social Insurance and the Allied Services*, Cmd. 6404, 1942, par. 11, p. 7.

[2] Her book, *The Disinherited Family*, first published in 1924, is the classic statement of the case for family allowances. A new edition, with an Epilogue by Lord Beveridge, and a chapter on 'The Family Allowances Movement, 1924–47', by Eva M. Hubback, was published in 1949. See also Mary Stocks, *Eleanor Rathbone*, particularly ch. viii.

[3] *Poverty and Progress*, p. 459.

[4] H. Tout, op. cit., p. 36.

poverty was bearing hardest on those who, in the interests of the future well-being of the community, as well as for their own sakes, should be the first to be protected from it, that is the children and the mothers who were bearing them and caring for them.[1] Moreover these conditions meant that many more people than were shown by the surveys to have been in poverty at a particular time must have suffered from it at one or more periods in their lives, and might be feeling its effects for the remainder of them.

The relatively high incidence of primary poverty among families where there were several young children was perhaps the strongest argument which could be brought forward in support of family allowances. Another contention which carried some weight during the years between the wars was that such allowances would encourage people to have more children. The decline of the birth-rate was becoming a matter of national concern, and it was recognised that it was due mainly to voluntary family limitation, which in its turn could be attributed, in part at least, to the increasing costs of rearing children, and the economic disadvantages suffered by parents of large families compared with the single or childless in the same social class.[2] It was acknowledged that family limitation was more widely practised among the middle and upper classes than among the semi-skilled and unskilled workers, to whom family allowances would bring the greatest proportionate increase in income, and some feared that the proposed allowances might be dysgenic in their effect, but the advocates of the allowances urged that at least they would be concrete evidence of the community's recognition of the importance of family life and the status of motherhood.

The third consideration put forward by its advocates in support of a scheme of family allowances was the unsatisfactory relationship between income during earning and the provisions made from public funds to cover periods when earnings were interrupted. These provisions included dependants' allowances, and in spite of the inadequacy of the insurance and assistance payments to bring the families benefiting from them above the 'human needs' standard, it might happen that a man whose family was large, but whose wages were small, could obtain more than he normally earned from State or social insurance funds when out of work. This was an obviously undesirable situation, and in order to prevent it, a 'wages stop', which meant that the assistance given would not be

[1] This was recognised during the war, when it was generally accepted that expectant and nursing mothers and young children should receive priority allocations of milk, eggs, and other essential foods.

[2] This issue is discussed by the Report of the Royal Commission on Population, 1949, ch. xiv, particularly pars. 366–9.

allowed to rise beyond the man's normal earnings, even if his family's needs entitled him to a larger sum, was operated by the Unemployment Assistance Board. It provided no real solution, however, as it simply meant that the body administering statutory relief to large families 'must in certain cases penalise children by underfeeding them, because in certain circumstances these children would again be underfed'.[1] As social insurance and assistance became more comprehensive it became increasingly clear that any system granting an income sufficient for subsistence when earnings were interrupted could only operate successfully as part of a policy of ensuring that the money coming into the house was also sufficient when the head of the household was in work. Suggestions that a national minimum wages policy would solve the problem were put forward from time to time, and minimum wage scales are actually enforced in certain occupations by means of Wages Councils.[2] It was generally recognised, however, that this was not the real answer to the problem, for 'a national minimum for families of every size cannot in practice be secured by a wage system, which must be based on the product of a man's labour and not on the size of his family'.[3] The only way out of the impasse was by the introduction of family allowances, and this was finally accomplished by the Family Allowances Act 1945, the first of the post-war 'social security' measures to become law.

The Act made an allowance of five shillings a week (raised to eight shillings by the Family Allowances and National Insurance Act, 1952) in respect of the second and each subsequent child in every family where there are two or more children who are under school-leaving age, or who are continuing their full-time education or are apprenticed, in which case they continue to count as part of the family for allowances purpose until the 31st July following their sixteenth birthday. Claims for family allowances may be made in respect of children on two grounds—the ground of 'issue', that is that the claimant is the parent or treated as the parent of the child,

[1] Joan Simeon Clarke, 'The Assistance Board' in William A. Robson, *Social Security*, p. 156. Third edition, 1947.

[2] Joint councils of workers and employers, together with a proportion of independent members. They were originally known as Trade Boards and were first set up in 1909 to cover certain 'sweated' industries. Their scope has been extended by successive enactments, the latest being the Wages Councils Act, 1945. The minimum wages decided on by Wages Councils can be enforced by prosecution in the criminal courts.

[3] Beveridge, op. cit., par. 411, cf. the words of Sir W. Jowett (then Minister of National Insurance) when introducing the second reading of the Family Allowances Act: 'Under any wage system as I conceive it, whether in a capitalist or socialist society, the remuneration which a worker gets must depend on the service he renders. It cannot depend on the size of his family.' Parliamentary Debates, Official Reports, Fifth Series, 1944–5, Vol. CCCCVIII, col. 2262.

or on grounds of 'maintenance'—that is that the claimant is providing more towards the cost of keeping the child than any other person. Married couples living together may claim for step-children[1] and legally adopted children as issue. Children of separated or divorced parents may be claimed for by either parent according to circumstances, but only one claim can be made in respect of each child, and if the parents cannot agree as to who shall make it, the Minister of National Insurance may decide the question. The mother of an illegitimate child can include the child in her family provided that it is living with her, or she is contributing five shillings a week towards it support.

Special provisions have been made to cover cases where the children are living apart from or have been removed from their parents. Children removed from their homes by order of the juvenile court and detained in remand homes or approved schools, or committed to the care of a local authority as a 'fit person' cease to count for family allowance purposes, and the same applies to children over whom the local authority has assumed parental rights.[2] On the other hand children away from home in hospital or school may continue to be included in their parents' family for allowances purposeseven though their absence be prolonged and no contribution is made towards their support, but if the children are in the care of a voluntary organisation, they cease to count for allowances purposes at the end of four weeks unless the claimant is contributing at least eight shillings a week towards each child's support.

Allowances are paid for the benefit of the family as a whole. They are financed out of moneys provided by Parliament and there is no test of means or insurance contribution. Either parent can draw them from the Post Office, but they belong to the mother, who should sign the claim form. They have undoubtedly been a welcome addition to the family's income where children are numerous and wages or salaries low in relation to the present cost of living, and are now taken for granted as one of the benefits to which the citizens of the Welfare State are entitled. There has been some discussion as to whether the present grant of eight shillings a week in respect of each second or subsequent child is adequate, however, and this raises two important questions. The first is whether the State should relieve parents of the whole of the financial responsi-

[1] Unless they are children by an earlier marriage which was ended by divorce.

[2] A child home on licence from an approved school, or allowed by the local authority which has assumed parental rights over him to return home for a limited period or remain with a relative or friend, may have an allowance claimed in respect of him. Family Allowances Act, 1945, Section 11.

bility of rearing their children and adjust allowances accordingly, or decide as a matter of policy that parents should shoulder at least part of the financial burden of bringing up their children themselves and limit the allowances for this if for no other reason. The second question of policy which arises is that of the extent to which the State should make its contribution towards the child's maintenance in direct grants to the parents, the alternative method being an increase in community services for the benefit of children.

Both the Beveridge Report and the more recent Report of the Royal Commission on Population contend that the cost of the child's maintenance should be shared between the parents and the community. Thus the Royal Commission on Population states quite emphatically: 'We think it only right that some substantial part of the cost of a family and each addition to it should be borne by the individual parents directly concerned.' 'A readiness to incur reasonable financial sacrifice for one's children is in our view an indispensable element in the responsible code of values which must form the basis of a successful population policy; and to attempt to build on the assumption that parents cannot be expected to make such sacrifices would be a profound psychological mistake.'[1] At the same time they consider the existing allowances inadequate particularly in view of the increased cost of living since allowances were introduced. They recommend the introduction of a graded scheme, with allowances of at least 10s. a week for children of eleven years of age and over, and of 7s. a week for younger children. At present the first child in each family is omitted from the scheme on the grounds that a man's wages should be sufficient to maintain himself, his wife and one child without State aid, but the Royal Commission argues that as a matter of long-term policy this should be reconsidered as 'it is usually the arrival of the first child that makes the most significant addition to a married couple's expenditure and the most radical change in their way of life'.[2] This is particularly true to-day when many couples marry young, but the wife returns to work until the coming of the first child. The Commission also recommends that a special lump-sum payment be made to meet the capital expenditure entailed by the birth of this child[3] in addition to the maternity grant payable under the National Insurance. Act, the granting of allowances as soon as

[1] Report of the Royal Commission on Population, par. 452, p. 168; cf. Beveridge Report, par. 417, p. 156.

[2] Ibid, par. 461, p. 170.

[3] This was estimated as £77 for well-to-do mothers, and £36 for manual workers' wives, in 1946. These figures include medical and nursing care during confinement, now covered by the National Health Service, but the Survey Committee state that 'a high proportion of the total expenditure in all groups went to purchase non-medical items such as the layette and the pram'. *Mater-*

pregnancy is established instead of at the birth of the child, and, if the present exclusion of one child from the scheme is continued but allowances are graded according to age, the exclusion of the youngest instead of the eldest child. It also recommends that family allowances be exempted from income tax.

Increased cash allowances are, however, not the only possible means of easing the financial burden of parenthood and ensuring freedom from want for the children of the nation. Another possible method which can either replace or supplement cash grants is that of extensive communal provision of food, clothing and medical care. Thus the Swedish sociologist, Alva Myrdal, who is one advocate of this method of meeting children's needs, considers that provision in kind is cheaper and more efficient than the granting of cash allowances. She points out that cash allowances may not be utilised for the benefit of the children, and argues that when society intervenes by placing an economic burden on other income receivers and thus compels them to participate in the cost of childbearing, it is also reasonable that society shall reserve the aid for the children and shall keep control of its utilisation'.[1] She also thinks that cash allowances tend to encourage the less responsible rather than the more responsible elements in the population, and her conclusion is that if the quality of the people is to be improved as well as their numbers increased, if every generation is to be 'healthier, happier, more able-bodied and more able-minded' than the one before, then the community's resources should be concentrated on a co-operative social policy of expanding social services integrated with the wider economic policies of the nation. Against these arguments and in favour of cash grants it can be contended that communal services involve heavy administrative costs,[2] and that cash grants leave the mother with more freedom of choice as to how she will feed, clothe and care for her child, and hence encourage her sense of responsibility for, and stress her close relationship with him. Cash grants encourage the child to look to the parents as the source of the necessities of life; communal

---

nity in Great Britain, a Survey of Social and Economic Aspects of Pregnancy and Childbirth undertaken by a Joint Committee of the Royal College of Obstetricians and Gynaecologists, and the Population Investigation Committee, 1948, p. 136.

[1] Alva Myrdal, *Nation and Family*, p. 144. The arguments summarised here are discussed at length in ch. ix, pp. 133–53.

[2] Lord Beveridge pointed out during the Second Reading Debate on the Family Allowances Act that the £57,000,000 to be given in family allowances would cost approximately £2,000,000 to administer; while £20,000,000 of the estimated cost of £60,000,000 estimated expenditure on the school meal service was allocated to overhead charges (Parl. Debates, Official Reports, 1944–5, Vol. CCCCVIII, col. 230).

services encourage him to look on the State as the universal provider.

This country's present policy is to give moderate cash allowances, and to supplement them by provision in kind, including meals and milk for children in grant-aided schools (now supplied free or at a small cost, but ultimately to be free); free or cheap milk and vitamin supplements for expectant and nursing mothers and young children and clothing for necessitous school children.[1] During the Second Reading Debate on the Family Allowances Act it was estimated by the Ministry of National Insurance that these would cost approximately £60,000,000 per annum, while the estimated cost of allowances of 5s. a week in respect of second and subsequent children was given as £59,000,000. The total cost of the assumption by the State of partial responsibility for the maintenance of the children of the nation is thus considerable, but if it can be shown it really ensures that no child need go hungry, cold or ill-clad, then it is worth while. Before this can be discussed, however, it is necessary to consider the provisions made to meet the needs of families whose earnings have been interrupted—the subject of the next chapter.

[1] These services are described in more detail in Chapters X and XI below.

CHAPTER III

SOCIAL INSURANCE AND SOCIAL ASSISTANCE

THE investigations into the extent and causes of poverty made between the close of the nineteenth century and the Second World War showed that it had two main causes—failure to relate income during earning to the size of the family and interruption or loss of earning power. In the chapter just concluded we have been considering the cash allowances and other provisions made by the community to overcome the want due to failure to relate income during earning to family size, and to benefit all families with children. The measures taken to support families whose incomes have been interrupted or discontinued form the subject of this present chapter. They consist of a nation-wide scheme of social insurance, covering the whole population and providing maternity, widowhood, sickness, unemployment, and industrial injury benefits, retirement pensions and a death grant, supplemented by a State scheme of social assistance providing for those whose needs cannot be met, or are inadequately met, by social insurance.

The underlying principle of social insurance is that all persons within its scope contribute at an agreed rate to an insurance fund, to which employers and the State also contribute, on the understanding that if certain contingencies befall them they can claim benefits from the fund at standard rates, without any test of need. The benefits are claimed as a right provided that the requisite number of contributions have been paid.

This method of providing against contingencies to which all are liable was widely adopted by trade unions and friendly societies during the nineteenth century. It was first applied on a national scale in this country by Mr. Lloyd George, who introduced it as a means of providing against temporary interruption of earnings by sickness or unemployment in 1911. The first health and unemployment insurance schemes were very limited in scope, but they were subsequently widened to include sickness and unemployment benefits for all manual workers and for non-manual workers with

limited incomes.[1] In time maternity grants and a contributory scheme providing for widows, orphans and old people were linked with National Health Insurance. The loss of income resulting from injury at work was not covered by social insurance, but was met by a scheme of 'workmen's compensation' by which individual employers were legally bound to compensate employees for the loss of earning power resulting from injuries sustained 'out of or in the course of employment', or from certain specified industrial diseases.

The pre-war social insurance schemes thus made some provision to meet the main contingencies of life, but they were insufficient in themselves as a safeguard against want. Only persons working 'under a contract of service or apprenticeship' were included, so that the small trader and others working on their own account were not protected, unless they joined a limited scheme providing health and pensions benefits to voluntary contributors introduced in 1938. Moreover the benefits received were inadequate to meet the needs of many families, particularly the sickness and disablement benefits, which did not include dependants' allowances, and the old age pensions, which only amounted to 10s. for the pensioner and 10s. for his wife. Further, there were many people in need but unable to claim insurance benefits, either because they failed to satisfy the contribution test, or had exhausted their right to benefit, or were faced with a difficulty not provided for in any scheme of social insurance.

The needs of individuals and families who had not qualified for benefit, or for whose needs the current rates of benefit were inadequate, or who were outside the scope of the social insurance schemes, were met by the various forms of social assistance. Thus there were non-contributory old age pensions for old people over seventy who had not qualified for the contributory pensions, and a nationally financed and administered scheme (Unemployment Assistance) for the able-bodied unemployed who had exhausted their right to benefit from the Unemployment Insurance Fund, or had never qualified for it; while Public Assistance, the lineal descendant of the Elizabethan Poor Law, provided assistance in cash or kind to destitute individuals and families unable to obtain help from any other source. In practice, it catered for a miscellaneous collection of unfortunates ranging from the respectable family, unable to manage on sickness or disablement benefit, to vagrants and unemployables. It also provided institutional care for orphans and other destitute children, and the old and infirm who

[1] Certain categories of workers such as private domestic servants and nurses of the sick were excluded from unemployment insurance, while teachers, civil servants, local government officials and certain other workers were excluded from both schemes as adequate provision was made for them in other ways.

had no one to care for them. In all forms of social assistance the financial help given consisted of grants from public funds, national or local, to individuals and families because they were in need and according to their needs. Consequently the giving of relief was preceded by an investigation of the applicant's[1] needs and resources, and the relief given was calculated on a scale designed to provide a bare maintenance, but no more.

Taken together, the social insurance and assistance schemes in operation on the eve of the Second World War were comprehensive and far reaching, and Lord Beveridge wrote at the beginning of his Report that 'provision for most of the many varieties of need through interruption of earnings and other causes that may arise in modern industrial communities has already been made on a scale not surpassed and hardly rivalled in any other country in the world'.[2] But reasonably good as they might be, they were far from perfect. They had grown up piecemeal, and there was little co-ordination between different schemes, which were administered by a medley of different government departments,[3] not to mention the local authorities who, under the general direction of the Ministry of Health, were responsible for the administration of the Poor Law. There were differences in contribution and benefit rates which led to serious hardships and anomalies,[4] and, while the benefits and allowances were sufficient to enable the families concerned to obtain the bare necessities of physical existence, they were insufficient to meet their human needs as measured by the austere standards of the social investigators of the time. It was *in spite of* these elaborate provisions that in the thirties between 10 per cent and 15 per cent of working-class families in England and Wales were living in primary poverty, and three-quarters to five-sixths of this poverty was due to interruption of earning power.[5]

The Second World War, like the First, acted as a stimulus to social and economic planning, and hardly was the immediate

[1] Notice the term used. An insured person *claims benefit*—it is his right; a person in need *applies* for *assistance* and can only obtain it if the official investigating the application is satisfied that the need is real and cannot be met in any other way. However, if need is proved, the applicant has a right to the assistance, and it cannot be refused on the grounds that he is 'undeserving'.

[2] Op. cit., par. 3.

[3] The most curious historical anomaly was perhaps the administration of non-contributory old age pensions by the Department of Customs and Excise.

[4] The most notorious of these was the absence of dependants' allowances from the National Health Insurance Scheme so that families with no other resources had to apply for Public Assistance as supplementary relief.

[5] An excellent critical description of the social insurance and assistance services at the time of the issue of the Beveridge Report is contained in William A. Robson (ed.) *Social Security*, Part I, first published 1943, second edition 1947.

danger of invasion past when far-seeing administrators began to consider what measures should be taken to prepare for the social advance which it was hoped would follow a victorious peace. As part of this planning Mr. Arthur Greenwood, who was then Minister without Portfolio, and in charge of reconstruction plans, set up a committee under the chairmanship of Sir William (now Lord) Beveridge 'to undertake, with special reference to the interrelation of schemes, a survey of existing national schemes of social insurance and the allied services including workmen's compensation, and to make recommendations'. The Report was issued eighteen months later, in December 1942, and proved to be a much more imaginative and far-reaching document than its somewhat uninspiring terms of reference would suggest. It was no less than a comprehensive plan to secure that all members of the community would at all times be free from want, and even this was regarded as part of a much wider and far-reaching programme, for 'Want is only one of five giants on the road of social reconstruction and in some ways the easiest to attack. The others are Disease, Ignorance, Squalor and Idleness.'[1] A concerted attack on all these giants was required if real progress was to be achieved, and Beveridge made clear that, in his view, the comprehensive insurance and assistance services proposed in the Report could only be fully effective if their introduction were accompanied by the introduction of children's allowances, if health and rehabilitation services were available to all members of the community, and if the mass unemployment of the inter-war years were avoided in future.[2] Given these, the proposed provisions to secure the maintenance of an adequate income if earnings were interrupted or brought to an end would fit into their proper place as part of a comprehensive scheme of social security.

The Beveridge Report was accepted in principle by both the National Government which was in power when it was published, and the Labour Government which succeeded it, and within two years of its publication steps were taken to implement it. The first necessity was to establish a unified central administration, and in November 1944 the Ministry of National Insurance was created. It is responsible for the administration of the social insurance and assistance services, including family allowances. The Family Allowances Act followed in June 1945, and 1946 saw the passing of the two Acts—the National Insurance Act and the National Insurance (Industrial Injuries) Act, which together created a compre-

[1] Beveridge, op. cit., par. 8, p. 6.

[2] These are the 'three assumptions' underlying the Social Security Plan. They are discussed in some detail in Part VI of the Report, pars. 409–43, pp. 153–65.

hensive and unified system of social insurance. Two years later the National Assistance Act, 1948, completed the scheme.

The insurance and assistance services brought into being by the legislation listed above embody the main proposals of the Beveridge Report, although there are some variations in detail. An important principle carried over from the Report is that, as in the years before the war, the maintenance of a minimum standard of life when earnings are interrupted shall be guaranteed by a scheme of social insurance, based on contributions from insured persons, their employers, and the State, supplemented by direct assistance from the State to persons whose needs are outside the scope of the contributory scheme and to those whose needs cannot wholly be met by the statutory benefits.

Social insurance as the first line of defence against want has thirty years' tradition behind it, is administratively convenient, and appeals to the average person, who likes to feel he has paid for the benefits he receives, and understands contributions to a fund ear-marked for a specific purpose better than general taxation. It has been criticised, however, on the grounds that the analogy between social and commercial insurance, which is implied by both the terminology used and the stress placed on the relation between contributions and benefits, is false and misleading, since if benefits are to be sufficient to meet the needs of insured persons they cannot be linked to contributions on an actuarial basis. Further, the emphasis placed on the contributory principle disguises 'the essential truth that everybody contributes in two ways—as an insured person paying a flat-rate contribution and as a member of the community paying direct and indirect taxation'.[1] Insurance contributions, these critics argue, are neither more nor less than a specifically allocated poll tax, and if the system is one of flat-rate contributions and benefits, as it is in this country, it is a regressive tax bearing more hardly on the poor than the well-to-do. On these grounds it is contended that it would be more equitable to merge contributions into income tax, which is related to capacity to pay.[2] On the whole, however, the decision taken by both Beveridge and the Government to retain a contributory scheme of social insurance as the strongest bulwark against want appears to have been justified by the working of the scheme since it came into operation. In general, the insurance contributions have been

[1] Gertrude Williams, 'Social Security Housekeeping' in Robson, op. cit., p. 381.

[2] Sir Ronald Davison 'Social Security 1906–46. The Contributory Principle', *Manchester Guardian* (21st March 1946); cf. Memorandum of evidence submitted to the Beveridge Committee by the Social Security Sub-committee of the Fabian Society, given as an appendix to Robson, op. cit., pp. 432 ff. The question is discussed in the Beveridge Report, pp. 107–9.

accepted with equanimity, but the payment of income tax continues to be unpopular with the wage-earner, and from the fiscal point of view alone 'it would be unwise to abandon revenue from a freely accepted but regressive tax in favour of one which is socially more just but less acceptable'.[1]

With certain specified exceptions national insurance is universal in scope. 'Subject to the provisions of this Act, every person who on or after the appointed day, being over school-leaving age and under pensionable age, is in Great Britain, and fulfils such conditions as may be prescribed as to residence in Great Britain, shall become insured under this Act and thereafter continue throughout his life to be insured.'[2] The exceptions are persons with an income of less than £104 a year, who, if they are not employed under a contract of service, may claim exemption from paying contributions, although this naturally involves loss of benefit rights, and married women for whom special arrangements have been made.

The position of a married woman varies according to her status. A woman who is an employed person, that is, works for gain for an employer, is insurable under the scheme, but may, if she wishes, claim exemption from paying contributions. In this case she will receive none of the social insurance benefits in her own right, but must rely on those to which she is entitled by virtue of her husband's insurance. The exemption of the woman from the payment of contributions does not excuse the employer from paying his share, nor does it exempt either the woman or her employer from contributing to the Industrial Injuries Insurance Fund. A married woman who is working on her own account, for example as a music teacher or milliner, is insured under the Act, but is excepted from the payment of contributions unless she chooses to pay them, in which case she is entitled in her own right to the benefits available to this category of persons. The married woman who was not insured when the scheme started, and has not worked for gain since, is not insured under the scheme, but she is entitled to a wide range of benefits from her husband's insurance. However, if prior to her marriage she was insured as an employed or self-employed contributor, she may elect to pay contributions as a 'non-employed' person and in this way receive certain benefits in her own right, the most material of which is the retirement pension. Alternatively, she may elect to remain in the insurance scheme without paying contributions. If she does this she retains her legal status as an insured person, and continues to be entitled to benefits for a limited period.

Apart from these two categories all persons over school-leaving

[1] Gertrude Williams, op. cit., p. 383.
[2] National Insurance Act, 1946, Section I (1).

age are compulsorily included in the scheme whatever their occupation, income or social class. Contribution and benefit rates do not vary with income, but they do vary according as to whether the insured person is 'employed', 'self-employed', or 'non-employed'.[1]

Employed persons are those who work 'under a contract of service or apprenticeship' for another person or organisation. They include wage- and salary-earners of all kinds, and their employers have to pay part of the contributions which are paid into the fund for their benefit. Employed persons qualify for all benefits under the general scheme, and are also insured under the National Insurance (Industrial Injuries) Act.

Self-employed persons work for gain, but on their own account, and include shopkeepers, farmers, solicitors, and other business

[1] MAIN RATES OF WEEKLY CONTRIBUTIONS
(as amended by the National Insurance Act, 1954)

CLASS I (EMPLOYED PERSONS)

	MEN			WOMEN		
Age	*Paid by Employee*	*Paid by Employer*	*Total*	*Paid by Employee*	*Paid by Employer*	*Total*
	s. d.	s. d.	s. d.	s. d.	s. d.	s. d.
18 & over	6 4	5 6	11 10	5 3	4 7	9 10
Under 18	3 8	3 3	6 11	3 1	2 8	5 9

Employees earning less than 30s. a week contribute at less than the above rates, employers proportionately more.

CLASS II (SELF-EMPLOYED PERSONS)

MEN		WOMEN	
Age	s. d.	Age	s. d.
18 and over	8 5	18 and over	7 2
Under 18	4 10	Under 18	4 3

CLASS III (NON-EMPLOYED PERSONS)

MEN		WOMEN	
Age	s. d.	Age	s. d.
18 and over	6 6	18 and over	5 2
Under 18	3 9	Under 18	3 1

and professional men who are not under the control of an employer. They are responsible for paying their own contributions, and are entitled to all benefits except unemployment benefit.

Non-employed persons do not work for gain. They may do a great deal of work voluntarily, but the income which they receive is not a direct reward for their work and is not dependent on it or related to it. They contribute at a lower rate than the other two classes, but are not entitled to sickness or unemployment benefit. They are, however, entitled to maternity benefit, widow's benefit, retirement pensions and the death grant.

The contribution rates are high compared with the pre-war rates. They bear hardly on the small business man who now has to contribute to the scheme on his own behalf, as well as paying increased contributions on behalf of his staff, and they also form a big item in the budget of the badly paid worker. On the other hand the benefits are comprehensive, and cover the principal contingencies likely to lead either to additional expenditure or to the interruption or cessation of earnings, namely birth, sickness, unemployment, the premature decease of the chief wage-earner, retirement and death at whatever age. These benefits are, of course, only paid if the claimant has fulfilled the contribution conditions laid down in the Act.[1] In general, these are two. In the first place a minimum number of contributions must have been paid since the entry of the claimant into insurance, and, in addition, a specified number must have been paid or credited[2] during the contribution year[3] prior to the claim. Entitlement to widow's benefit or to a retirement pension depends, not on the record of the previous contribution year, but on the average number of contributions paid or credited each year since entry into insurance.

Maternity benefits have twice been altered since 1946, by the National Insurance Act of 1953 and that of 1954, which comes into effect in the spring of 1955. They now consist of a maternity grant, a maternity allowance and a home confinement grant.

The maternity grant is a lump sum of £10 for each birth, paid on confinement to all women, married or single, who have either paid the necessary contributions themselves or who can claim by virtue of their husband's insurance. Not less than twenty-six contributions must have been paid by the relevant person since entry

[1] National Insurance Act, 1946. Third Schedule, 'Contribution Conditions'.

[2] Contributions are credited to an insured person for weeks of certified sickness or registered unemployment or during the receipt of maternity or injury benefit. During these times he is not required to make payments himself.

[3] The contribution year is dated at different periods for different people—for a quarter of the insured population it starts in March, for a quarter in June, for a quarter in September, and for a quarter in December.

into insurance, and twenty-six contributions must have been paid or credited during the last complete contribution year before the beginning of the benefit year comprising the relevant time.

The home confinement grant of £4 is paid to women whose confinement did not occur in accommodation provided under the National Health Service or Part III of the National Assistance Act.

The maternity allowance, which is designed for the woman who goes out to work, is a welcome addition to the insurance scheme, for it removes a serious anomaly. Under previous health insurance enactments normal pregnancy was not regarded as a sickness, and although there was a good deal of latitude in their interpretation, a woman who, in the interests of her own health and that of her child, wanted to give up work some weeks before her confinement, was not certain of being able to obtain insurance benefit, and might be in serious financial difficulties. Now, provided the necessary contribution conditions have been fulfilled, she is entitled to an allowance of 40s. a week for 18 weeks beginning the eleventh week before the confinement is expected. To qualify for this not less than 50 contributions of the appropriate class must have been paid or credited to the claimant for the 52 weeks immediately preceding the thirteenth week before the expected week of confinement. Of these not less than 26 must have been contributions actually paid. Until the passing of the National Insurance Act, 1953, married women who had exercised their right not to contribute could claim maternity allowances, but this is now impossible. Apart from this, qualifying conditions are easier than in the original Act, under which the 52 weeks during which contributions had to be paid ended immediately before the period during which the allowance was payable, that is about six weeks before confinement. Now the woman can give up work much earlier, which should benefit both mother and child.

The treatment of widows is more flexible under the present scheme than it was under the former Widows, Orphans and Contributory Old Age Pensions Act. Under this Act the widow of an insured person received 10s. a week for life, and small additional payments if there were dependent children. The contribution conditions and benefit rates meant that a young able-bodied woman, quite capable of self-support, could claim what was in effect pocket money for the rest of her life if she lost her husband within a few years of marriage, while a widow with children, or an elderly or incapacitated woman, without other resources, had to apply for Public Assistance to supplement a pension which was quite inadequate for her needs. Present-day legislation provides continuing benefits for widows unable to support themselves either because they are elderly or infirm or have young children to care for,

but, after an initial period to enable her to readjust herself to changed circumstances, the young, able-bodied widow without children is expected to support herself.

A widow obtains benefit by virtue of her husband's insurance. He must have paid at least 156 contributions into the insurance fund, and the yearly average of contributions paid or credited since entry into insurance must have been at least fifty. With the increases granted by the 1954 Act a widow receives a widow's allowance of 55s. a week for the first 13 weeks after her husband's death, together with 11s. 6d. for the first child under school-leaving age, and a supplement of 3s. 6d. to the family allowance of each of the younger children. At the expiration of this period she receives no further benefit from the insurance fund unless she is over fifty, incapacitated by bodily or mental infirmity, or is the mother of a child or children under school-leaving age. In the latter case she is entitled to a 'widowed mother's allowance'. This was originally 26s. a week for the woman herself and 7s. 6d. for the eldest child—younger children being excluded from insurance payments on the ground that they were benefiting from the family allowance scheme. Moreover, the widowed mother could not earn more than 30s. a week without corresponding reductions being made in her allowance. Legislation passed in 1951, 1952 and 1954 has improved the widowed mother's position. The allowance for herself and her first child is increased to 51s. 6d., and weekly allowances of 3s. 6d. in addition to the family allowances are payable for each of the younger children. Further, she is now permitted to earn up to £3 a week without her allowance being affected. This last concession is confined to widowed mothers, and is a recognition of the special position of the woman who through the death of her husband has become at one and the same time 'the wage-earner, the home maker, and the protector of her children', with all the responsibilities which she formerly shared with her husband on her own shoulders.[1] If a widowed mother is over forty when she ceases to be entitled to a widowed mother's allowance, and ten years have elapsed since the date of her marriage, she can claim a pension of 40s. a week until she reaches the age of sixty when a retirement pension will be substituted. An elderly widow who was between fifty and sixty at the date of her husband's death, and who at that time had been married at least ten years, is entitled to claim a widow's pension of 40s. a week, and the pension can also be claimed by younger women incapaci-

[1] Dr. Edith Summerskill (Minister of National Insurance), speaking in the House of Commons on the Committee Stage of the National Insurance Bill, 9th May 1951. Parliamentary Debates (*Hansard*), Vol. CCCCLXXXVII, No. 104, col. 1992.

tated by mental or physical infirmity. Women whose husbands died before the introduction of the new scheme continue to receive the old pension of ten shillings a week, but it has been increased to 40s., with the addition of children's allowances at standard rates for those who have young children, and to 40s. for the elderly or infirm. Widow's benefit ceases to be payable if the woman marries again, or while she is cohabiting.

Guardian's allowances of 18s. a week are payable in respect of orphan children one of whose parents was insured.

One of the many improvements brought about by the National Insurance Act, 1946, is that contribution and benefit rates for sickness and unemployment now correspond. In either case the claimant must have paid not less than twenty-six contributions between entry into insurance and the date of his claim, and must have at least fifty contributions of the appropriate class credited to him for the contribution year prior to his claim. Benefit does not start until the fourth day of sickness or unemployment, but a claimant will receive back pay for the first three days if he is sick or unemployed on twelve days during the period of thirteen weeks beginning with the first day. The disqualifications contained in the previous schemes are continued. For example, unemployment benefit is not payable if the unemployment is directly due to a trade dispute, and it may be disallowed for a maximum period of six weeks if the claimant left work of his own accord, or was dismissed for misconduct or if he refuses suitable work, while sickness benefit may be forfeited for a maximum period of six weeks if the claimant refuses medical examination or fails to submit himself for treatment without good cause, or does not comply with certain prescribed rules of behaviour.

The standard weekly rate of sickness and unemployment benefit for persons over 18 except married women is 40s., plus 25s. for an adult dependant and children's allowances of 11s. 6d. for the eldest child and 3s. 6d. for subsequent children. If 156 contributions have been paid, sickness benefit continues indefinitely; otherwise it is limited to 312 days. There is no reduction for the first eight weeks in hospital, although the sick person is receiving free board, lodging and treatment under the National Health Service Act, but at the end of this period benefit is reduced by 7s. 6d. a week if the claimant has dependants, if not, by 15s. 0d. a week. There is no further reduction for the in-patient with dependants, provided he arranges that all but 7s. 6d. a week (which he is allowed for his own personal expenditure) is paid to his dependants, but the patient without dependants has his benefit reduced to 7s. 6d. a week after a year in hospital (12s. 6d. in cases of respiratory tuberculosis). These reductions also apply to widows' and retirement pensions.

Unemployment benefit normally continues for 180 days, but this period may be extended if the claimant has a good insurance record up to a maximum of 492 days (nineteen months). The special 'extended unemployment benefit' which was payable under the National Insurance Act, 1946, to persons who had exhausted their statutory rights to benefit if this were recommended by a local insurance tribunal was discontinued in July 1953, since the contingency of exceptional unemployment against which it was originally provided had not materialised.

It is well known that one of the most difficult problems facing the framers of the post-war social insurance legislation was that of making adequate provision for the elderly without imposing too great a strain on the fund. The steady decline in the birth-rate between the 1870's and the 1930's had combined with a greater expectation of life to increase the proportion of old people in the community compared with men and women of working age, and it was realised that this proportion was bound to go on rising. Hence any scheme providing universal pensions at subsistence level would inevitably be costly and would become more so as time went on.[1] Moreover, because of the shortage of man-power the services of the elderly still capable of work were needed to increase production, and any pension scheme should therefore encourage men and women to remain in employment as long as possible.[2] Meanwhile, the old people themselves were making increasing claims on the community and becoming more vociferous in their demands.

In the event it was decided that the minimum pensionable age should remain at the 1940 level, namely sixty-five for men and sixty for women, but that the pension should not be payable until the claimant retired from regular work.[3] The basic rates payable at the minimum pensionable age were fixed at 26s. a week for a man or woman claiming by virtue of his or her own insurance, and 16s. for the uninsured wife of a pensioner, but in order to encourage elderly persons to go on working after reaching the minimum age,

[1] According to the original estimates of the Government Actuary, in which expenditure on unemployment benefit was based on a rate of unemployment of 8½ per cent, the cost of retirement pensions was expected to be about half the total expenditure. In the First Interim Report by the Government Actuary for the period 5th July 1948–31st March 1950, it is stated that with payments for unemployment benefit on a much lower level than was expected, retirement pensions already account for nearly two-thirds of the total outgoings on benefits and administration. The expected outgo for the year ending 31st March 1950 was £241,000,000, the actual outgo £249,000,000. Op. cit., pp. 10–11.

[2] This issue is discussed in more detail in Chapter XVII.

[3] Persons claiming retirement pensions can still do casual or intermittent work, 'not inconsistent with retirement', and can earn up to 40s. a week without their pensions being reduced.

it was decided to increase these amounts by 1s. a week for every six months' further employment until the age of seventy in the case of a man and sixty-five in the case of a woman.

Since the passing of the 1946 Act the cost of living has risen more steeply than had been anticipated, and this had led to recurrent demands for increases in pension rates to meet the needs of elderly men and women living in straitened circumstances. Expenditure on retirement pensions is a serious drain on the insurance fund, however, and the position is worsening. The Government Actuary, in his First Quinquennial Review of the operation of the Act, estimates that total expenditure will increase from £535m. for 1954–5 to £917m. for 1979–80, this increase being mainly due to a rise of about £310m. in the cost of retirement pensions. After 1955–6 annual expenditure will exceed income to an increasing extent, the deficiency rising from £18m. for 1959–60 to £364m. for 1979–80. This particularly large increase is in some measure due to the granting of full insurance rights to persons entering the scheme relatively late in life whose contributions bear no relation to the pensions they will receive.[1] The whole situation has been reviewed by a Committee with Sir T. Phillips as Chairman. It concludes that 'some increase in the present minimum pension ages appears to be inevitable', and recommends that provisions should be made to raise the ages at which the standard rate of pension be claimed by one year after an interval of not less than five years and that the ages should ultimately be raised to 68 for men and 63 for women.[2]

The most recent legislation (National Insurance Act, 1954) deals solely with pension rates and makes no attempt to alter age conditions. It provides for the raising of the pension rate to 40s. for all persons except those women whose pension is payable by virtue of their husband's insurance and he is alive. Such women receive 25s., which is also the amount payable in respect of an adult dependant, so that the amount received by married couples in the majority of cases is 65s. Earlier amending legislation had already raised the increment which can be claimed on later retirement from 1s. to 1s. 6d. a week for each six months' extra work. A recent survey by the Ministry of Pensions into reasons for retiring or continuing at work has revealed that the great majority of the 12,009 men questioned said that they knew that a higher rate of national insurance pension could be obtained by staying at work, but only seven in a

[1] National Insurance Act, 1946. Report by the Government Actuary on the First Quinquennial Review, pars. 94 and 95, p. 29.

[2] Report of the Committee on the Economic and Financial Problems of the Provision for Old Age. Cmd. 9333, December 1954, par. 191, pp. 50–51.

thousand said that this was their reason for staying on, although one in four said that their knowledge of the arrangement had influenced them in making their decision.[1] The earnings rule which originally barred a person claiming a retirement pension from earning more than £1 a week without his pension being reduced, has been modified since to allow him to earn up to £2.

The death grant is the only complete innovation among the benefits of recent social insurance legislation, the others being extensions or modifications of existing provisions. Its introduction has been welcomed by social workers and others, who were aware of the sacrifices made by many families to maintain their weekly payment to the 'burial club' so as to be sure of a decent funeral for themselves and their loved ones. Lord Beveridge estimated that the administration costs of the Industrial Life Offices which conducted the greater part of this business were as high as 7s. 6d. in the £,[2] and pointed out that a large number of policies lapsed each year as the owner was unable to keep up the premiums.[3] These considerations led him to recommend that grants, adequate to cover the cost of a simple but seemly funeral, be included among the benefits of the proposed social insurance scheme, and this recommendation was adopted. The death grant is payable in respect of an insured person, or his wife, child, or widow, and ranges in amount from £20 for an adult to £6 for a child under three years.[4]

The National Insurance Act thus provides cash benefits for insured persons and their dependants when they are faced with a reduction in income or increase in expenditure caused by the birth of a child, the death of a husband or father, the sickness, unemployment or retirement of the chief wage-earner. A separate but linked scheme makes special provision for persons injured at work, or suffering from diseases directly attributable to the nature of their employment. This scheme, which is embodied in the National Insurance (Industrial Injuries) Act, 1946, makes a com-

[1] *Reasons given for Retiring or Continuing at Work.* Report of an Enquiry by the Ministry of Pensions and National Insurance 1954, par. 30.

[2] Beveridge, *Social Insurance and the Allied Services*, par. 157, p. 66.

[3] 'In each of the three years just before the war the number of policies in six of the largest offices which, after some premium had been paid on them, ended prematurely, by lapsing, surrender for cash, or being made free for a reduced sum, was about two-thirds of the total number of policies issued and taken up in the year, more than half of these two-thirds were forfeited completely.' Ibid., par. 186, p. 73.

[4] By the terms of the Act this grant did not become payable until a year after the beginning of the main scheme, i.e., 5th July 1949. At present no payment is made on the death of a person who attained pensionable age before 5th July 1948, and the amount is halved for a person who was within ten years of pensionable age on that date, while there is no payment in respect of children born before 5th July 1948 and dying before the age of ten years.

plete break with previous methods of dealing with these particular misfortunes. Before it came into operation industrial injuries were outside the scope of social insurance. Each employer was legally liable to pay compensation to any workman injured during the course of his employment, the amount paid being related not to the extent of the injury, but, subject to a statutory minimum, and after 1940 including dependants' allowances, to the workman's earnings. The onus of making and enforcing his claim, if need be in court, rested with the injured person, who, unless he was backed by a powerful trade union, or able to obtain legal aid in some other way, might be at a serious disadvantage owing to his ignorance of the law, for this, although apparently simple, was exceedingly difficult to interpret, and to his unfamiliarity with court procedure. The scheme was concerned solely with monetary compensation for loss of earning power, and was not associated with any measures of rehabilitation. In general it was unsatisfactory from the point of view of both worker and employer.

The present scheme is a form of social insurance, administered by the Ministry of National Insurance. Workers, employers, and the State all contribute to a common fund, the contribution rates being 6d. from employer and 5d. from worker for an adult man, 3d. from worker and 4d. from employer for an adult woman, 3d. for a boy and 2d. for a girl under eighteen. The benefits are payable any time after a person enters employment—there is no contribution test—and are of three kinds, injury benefit, disablement benefit, and death benefit.

Injury benefit is payable for six months at the rate of 67s. 6d. a week for an adult, 50s. 8d. for a young person between the ages of seventeen and eighteen, and 33s. 9d. a week for those under seventeen. A child of less than school-leaving age is entitled to injury benefit if injured while undertaking paid work. If he was engaged in full-time employment, for example at a harvest camp, at the time of his accident he is entitled to 33s. 9d. a week; if in part-time employment, for instance, delivering milk, to 11s. 6d. a week. Dependants' allowances are paid at the usual rates, and persons under eighteen with dependants are entitled to benefit at the full adult rate.

At the expiration of six months, injury benefit is replaced by disablement benefit provided that a Medical Board is satisfied that there is likely to be a permanent loss of physical or mental faculty. In the case of a minor injury this may take the form of a lump sum gratuity, not exceeding £225, but where the disablement is more serious it consists of a weekly pension assessed, not in relation to the worker's previous earnings, but according to the

extent to which he is disabled 'by comparison with a normal healthy person of the same age or sex'. It is not affected by subsequent earning, though an 'unemployability supplement' of 40s. a week is payable if the injured person is permanently incapable of work, or of earning more than £52 a year. This basis of assessment involves a radical change of outlook. It recognises 'a certain similarity between the position of the soldier wounded in battle and that of a man injured in the course of his productive work for the community. Neither is liable to have his pension reduced on account of what he may earn after the injury; each is compensated not for loss of earning capacity but for whatever he has lost in health, strength and the power to enjoy life.'[1] Dependants' allowances are payable if the beneficiary is entitled to an unemployability supplement or is receiving approved hospital treatment.

Apart from the concessions made to widowed mothers by the National Insurance Act, 1951, the widow of a man killed in an industrial accident or dying as the result of an industrial disease fares better than the woman whose husband has died a natural death. The widow considered able to earn her own living receives a pension of 20s. a week; the one who has children to look after 45s. a week, together with an allowance of 11s. 6d. for the eldest child and 3s. 6d. for each of her subsequent children. In either case her pension ceases on remarriage, but she then receives a gratuity equal to fifty-two times the weekly pension to which she was entitled.

Provision is made under the Act to enable the parents, and under certain conditions other relatives, of a person killed at work to obtain benefit if they were maintained by him at the time of death.

The administration of the industrial injuries scheme necessarily involves numerous decisions, both administrative and medical. In general, claims for benefit and questions arising out of such claims are dealt with by the local Insurance Officer, but he may refer the case, or appeals may be made from his decision, to a local appeal tribunal, and from there to the Industrial Injuries Commissioner, whose decision is final. Medical Boards and a Medical Appeal Tribunal assess the degree of disability resulting from the disease or accident and deal with other medical questions.

One of the criticisms made of the old workmen's compensation system was that it did not contribute in any way to the rehabilitation of the injured workman, and might indeed be said to discourage him from doing all in his power to speed his own recovery, since he feared the loss of his compensation rights. Present legisla-

[1] Ministry of Reconstruction, *Social Insurance*, Part II, 'Workmen's Compensation. Proposals for an Industrial Injury Insurance Scheme', Cmd. 6551/44.

tion, by dissociating industrial injury and disablement benefits from earning power, and expressedly providing that disablement pensions are not affected by subsequent earnings, encourages an injured person to fit himself for work again as quickly as possible. Facilities for rehabilitation and, if necessary, retraining, have been established under the Disabled Persons (Employment) Act,[1] and the National Insurance (Industrial Injuries) Act includes provisions designed to encourage injured workers to take advantage of these facilities.

The industrial injuries scheme thus makes comprehensive provisions to meet the needs of persons injured at work or suffering from diseases resulting from the nature of their employment, but this does not release employers, workers and the State from their responsibility of doing all in their power to reduce the number of such accidents or the incidence of these diseases. This is recognised by a clause in the Act[2] which enables the Minister of National Insurance to promote research into the causes, incidence and methods of prevention of industrial disease or accidents, either by conducting such research himself or contributing to it.

The National Insurance (Industrial Injuries) Act rounds off the social insurance provisions, and completes the first line of defence against want. But strong as this defence is, it has its loopholes, and if all members of the community are to be protected from want in all circumstances there must be a reserve in the form of a scheme of social assistance as comprehensive and universal in its scope as the insurance service. This need is met by the National Assistance Act, 1948, the passing of which meant the replacement of the Poor Law and the existing specialised assistance services for the old, the long-term unemployed, the blind and the tuberculous by a unified national scheme of financial assistance to all in need. The Act also contains provisions making local authorities responsible for residential accommodation and welfare services for the aged and handicapped, but these services are discussed in later chapters.[3].

Since the National Assistance Act came into force financial assistance to those in need has been given from national funds, and the administration of this relief is in the hands of the National Assistance Board. The Board was constituted in 1934 to administer a state system of relief to able-bodied unemployed men and women who had exhausted their right to benefit from the insurance fund, or whose needs were not met by unemployment benefit. Its scope was gradually widened, and during the war it became responsible for the ministration of a wide variety of schemes of monetary assistance to persons in need. The original title of Unemployment Assistance Board ceased to be appropriate, and in 1940 it was re-

[1] Discussed in Chapter XVIII. [2] Section 73. [3] Chapters XVII and XVIII.

christened the Assistance Board, a title retained until the implementation of the National Assistance Act in 1948, when it became the National Assistance Board.

The Unemployment Assistance Board was established at a time of bitter controversy about the treatment of the unemployed, and the Board was definitely constituted in such a way as to make it independent of direct Parliamentary control, and to keep the administration of relief free from political pressure—a policy which has been continued up to the present. Hence members of the Board are appointed by Royal Warrant for specified periods, their salaries are charged to the Consolidated Funds, and they are precluded from becoming members of the House of Commons.[1] Parliamentary questions about the Board's work are addressed to the Minister of National Insurance to whom the Board must submit an annual report for presentation to the House. The Beveridge Report envisaged that one department would administer both social insurance and social assistance,[2] but this recommendation was not accepted, and the administrative distinction between the Ministry of National Insurance, which through its Minister is directly answerable to Parliament, and the National Assistance Board remains.

The policy of the Board is carried out by civil servants, who staff a network of Regional and Area Offices. Direct contact with the public is made through the 376 Area Offices, while the eleven Regional Officers supervise and co-ordinate the work in their respective regions.

Though open to criticism in some respects, this administrative set-up works reasonably smoothly and well, and the increasing responsibilities given to the Board can be regarded as a meaure of the growth of public confidence in the ability of its officers to administer a wide range of relief services with efficiency and humanity.[3]

In order that the Board may benefit from local knowledge and experience, Advisory Committees have been set up in different parts of the country.[4] They deal with general questions such as

[1] These conditions are laid down in the First Schedule of the Act which also decrees that the Board shall consist of a Chairman, Deputy Chairman and from one to four other members. One member must be a woman.

[2] Beveridge, op. cit., p. 141, par. 369.

[3] In addition to its own special work of assisting persons in need the Board makes investigations into circumstances on behalf of other Departments. For example, the Legal Aid Act, 1948, provides for free or assisted legal aid to persons whose 'disposable incomes' are below a certain level. These cases are investigated by the Assistance Board. See Chapter VIII.

[4] These are provided for in Section 3 of the National Assistance Act which lays it down that: 'For the purpose of securing that full use is made of the advice and assistance, both on general questions and on difficult individual cases, of persons having local knowledge and experience in matters affecting the functions of the Board, the Board shall arrange for the establishment of advisory committees . . . to act for such areas as the Board think fit.'

rent allowances, and not with individual cases. For this purpose they appoint Area Sub-committees, one for each Area Office, whose function is to advise the Area Officer about difficult or special cases. While useful work is done, in general neither the Advisory Committees nor their Sub-committees appear to function very effectively. They have no administrative responsibility, and in the main a Sub-committee's work is limited to dealing with a few arbitrarily selected applicants, often those who have exhausted the patience and ingenuity of everyone else, and whose prognosis is bad, if not hopeless. Nevertheless, the existence of the Advisory Committees and Sub-committees means that men and women from industry, local government and the related social services, who are willing to undertake this service and are selected for it, gain some insight into the day-to-day work of the Board. They also gain some understanding of the problems, particularly the more intractable ones, with which its officers have to deal, of the ways in which these are being met, and the difficulties which have to be surmounted. In their turn the Committee members can give the Board's officers the benefit of their knowledge of local conditions and of their experience in related fields of work. Moreover, however imperfectly they may function, Advisory Committees are at least an official recognition by Parliament and the Board that, although National Assistance is centrally administered, the real work is carried out in the local offices, and should be the concern of local people, and related to local conditions and other services in the area.

Like the National Insurance Act, the National Assistance Act is universal in scope. Any person over the age of sixteen may apply for assistance, and the amount granted will be sufficient to meet both his needs and those of his dependants. Children under the age of sixteen not in the care of parents or guardians are not assisted under this Act, but special provision is made for them by the Children Act which came into operation at the same time.[1] The Board is also precluded from giving general assistance to persons in full-time employment, except in emergencies, but it may help them to tide over the first few days in work after a spell of unemployment, and continuing assistance may be given to a disabled person not working under a contract of service whose earning power has been substantially reduced in comparison with others doing similar work.[2] The National Health Service Act, 1951, which imposed a charge amounting to half their cost on dentures and spectacles provided under the National Health Service, expressedly authorizes the Board to assist people in need of these appliances, but unable

[1] These provisions are discussed in Chapter XIII.

[2] National Assistance Act, 1948, Section 9.

to afford them, even if they are in full-time work.[1] National Assistance may not be given to a person directly participating in a trade dispute unless he is destitute, although the requirements of his dependants may be met if need is proved.

Since, apart from the exceptions just mentioned, anyone in need can obtain help from the National Assistance Board, the variety of cases dealt with is very large. The Board's clients include persons who have failed to qualify for insurance benefit, or who have exhausted their right to benefit, or for whose needs the standard benefit is insufficient. There are also a number of cases outside the scope of the insurance scheme, for example, the deserted wife unable to go out to work as she has young children to care for, the wife and children of a man serving a term of imprisonment, the unmarried mother and her young child. Old people over seventy who are not entitled to retirement pensions, and blind persons over forty, can claim special non-contributory pensions, provided that they can satisfy a test of need, nationality and residence, and these pensions are administered by the Board, which has also taken over from the local authorities the responsibility for making special allowances to needy blind persons and to persons who have suffered a loss of income as a result of undergoing treatment for pulmonary tuberculosis.

Assistance is normally given in cash, although under special circumstances it may be given in kind. Except in cases of emergency it cannot be granted without a prior investigation by an officer of the Board into the applicant's needs and resources, and regulations, approved by Parliament,[2] determine the scale on which relief shall be given. The 'needs test' is a personal one, and the only legal obligations to support relatives recognised by the Act are those of a man to maintain his wife and children, and a woman to maintain her husband and children, including her illegitimate children.[3] Although, in general, assistance has to be given on the scale laid down, the Board's officers have discretionary powers which enable them to meet the special needs of individual cases, such as those, for example, of an infirm old person who may require an additional allowance to enable him to obtain domestic help or pay for laundry. Further, the Board is empowered to make lump-sum payments to meet exceptional needs, such as clothing, tools to enable an unemployed man to take a particular job, or

[1] National Health Service Act, 1951, Section 4 (2).

[2] The National Assistance (Determination of Needs) Regulations, 1948. Statutory Instrument, 1948, No. 1334, as amended by the National Assistance (Determination of Needs) Amendment Regulations, 1954 (S.I. 1954, No. 1704).

[3] National Assistance Act, 1948. Section 42 cf. the provisions of the Poor Law concerning liable relatives.

bedding so that a tuberculous person can sleep alone; or fares to enable parents to visit a child in a distant hospital. Until recently the Board was precluded from meeting any medical needs, but, as we have already seen, it can now make payments to persons requiring dentures or glasses, but unable to afford the charge authorised by recent National Health Service Acts.

The function of the National Assistance Board is thus to give financial assistance to persons in need, but it is recognised that this is not only an end in itself but can be used as a means of promoting the general well-being of the person or family so helped, and the National Assistance Act expressedly directs the Board to exercise its functions 'in such a manner as shall best promote the welfare of the persons affected by the exercise thereof'.[1] This is taken by the Board as meaning that the officer handling a case must have a real personal concern for the well-being of the client, but not that an applicant for assistance is necessarily in need of comprehensive care. The Board proceeds on the assumption that persons in receipt of assistance are in the main competent to manage their own affairs, and differ from others only in point of income, and hence that its primary business is 'to ensure that the people applying to them have a sufficient income, and have it in the majority of cases with as little trouble and inconvenience as possible'.[2] It recognises that there are a minority of cases who need more help and attention than this, since their financial need is but one symptom of their general social maladjustment, and unless financial relief is accompanied by some attempt at social rehabilitation no real improvement in their condition can be expected, but it does not regard such social rehabilitation as within its scope. It often happens, however, that it is because of financial need that such a family first comes into touch with the social services, and financial assistance, carefully administered and adjusted to its needs, may be a potent factor in its rehabilitation. Hence, the Board must accept some social responsibility for those cases which need such care as well as financial aid. At least its officers must be able to recognise the need, and maintain close co-operation with those organisations whose functions it is to provide the social care.

Apart from these 'social problem' cases the Board's officers are daily confronted with requests for assistance of all kinds, and with human needs so varied that they can only be met by the exercise of considerable resource and initiative, combined with sympathy and understanding, and the imaginative use of discretionary powers on

[1] Section 2 (1). It is noticeable that this direction is given right at the beginning of the Act, before any of the Board's specific functions are discussed.

[2] Report of the National Assistance Board for the year ended 31st December 1949. Cmd. 8030, p. 16.

the part of the officers concerned.[1] This being the case, the quality and outlook of the staff, and particularly those members of it who are in direct contact with clients, are particularly important. The present practice, by which the interviewing and visiting are done by higher-grade officers who have power of decision as well as of enquiry and can see the application through all its stages,[2] is an improvement on the former division of duties, and the increasing attention being given to staff training with its emphasis on relations between officer and client[3] is a hopeful sign. This training is all 'in-training' however, and the Board would probably gain if some, at least, of its executive officers shared in the basic training given in the Social Science Departments of the universities, not only because of the background knowledge which they would acquire, but because of the contacts they would make.

The National Assistance Act completes the legislation designed to secure a subsistence income for all families under all circumstances. The cost of making this provision is heavy. During the year ending the 31st March 1953 contributions to the National Insurance Fund from insured persons and employers totalled approximately £447,604,000, while payments from the Exchequer made over the same period amounted to £65,326,000 exclusive of a relatively small payment in respect of extended unemployment benefit. The net expenditure of the National Assistance Board for the year 1953 was about £126,600,000. To these amounts must be added the cost of family allowances, which, in the year ending March 31st, 1953 amounted to £87,170,689, if our social security budget is to be reasonably complete.

The object of this expenditure is to ensure that 'every citizen willing to serve according to his powers has at all times an income sufficient to meet his requirements',[4] and the Beveridge Plan, from which this quotation is taken, envisaged that when earnings were interrupted these requirements would be met in the main by insurance benefits. The social insurance scheme was designed to guarantee the income needed for subsistence in all normal cases, assistance being required in exceptional circumstances only. Accordingly the benefit rates proposed in the Beveridge Report were based on careful calculations of the amounts required for meeting subsistence needs at 1938 prices, and an increase of 25 per cent was made to cover the estimated difference between the pre-war and post-war cost of living.[5] But, in fact, the cost of living has risen very much more steeply than had been anticipated, and at

[1] Examples of these are given in Appendix I / I of the Report of the National Assistance Board, 1949.

[2] Ibid., p. 43. [3] Ibid., p. 44.

[4] *Social Insurance and the Allied Services*, p. 165, par. 444.

[5] Ibid., Part III, Section 1.

the time of writing it is still rising. Consequently, even with the most recent increases, the standard insurance benefits are, in the case of householders, insufficient in themselves to meet the family's basic needs including rent and household necessities. This may be seen by comparing them with the National Assistance Board's scales introduced at the same time. When the National Insurance Act, 1954 comes into operation the standard rate of insurance benefit for a husband and wife will be 65s.; the National Assistance Board scale rate is 63s. exclusive of rent. In families where there are children the gap becomes wider for, while the amount allowed for a child by the National Insurance Act is 11s. 6d., the National Assistance Board scale rates vary from 17s. for a child between 11 and 16, and 14s. for a child 5 to 11, to 12s. for a child under 5. Thus as in the days before the war, persons and families whose earnings have been interrupted and who are without other resources must apply for assistance, and subject themselves to a means test, if they are to receive payments adequate for subsistence. This departure from one of the principles of the Beveridge Plan may be considered reasonable or necessary in view of the economic position, but that it is such a departure should be recognised.

In spite of the rising cost of living which threatens to reduce their efficacy to ensure freedom from want, social insurance and assistance, together with family allowances, have done a great deal to rid the country of primary poverty in its most acute form. In 1950 Seebohm Rowntree, assisted this time by Mr. G. R. Lavers, made a third social survey of York. The investigations they made showed that, taking just over £5 a week for a man, wife and three children, as the poverty line, with comparable rates for families of different sizes, the proportion of the working class in poverty had been reduced since 1936 from 31·19 per cent to 2·77 per cent. Had the welfare measures in operation in 1950 been identical with those in force in 1936 the proportion in poverty would have been reduced to 22·18 per cent.[1] The standards adopted by Rowntree and Lavers and their conclusions have been challenged,[2] and prices have risen still further since the survey was made. While improvements since 1936 have been very considerable, there are still many people, particularly the infirm and the old, who if no longer in desperate poverty, have a hard struggle to make ends meet. Moreover, while the measures described so far have done much to reduce primary poverty, they can do little to overcome secondary poverty, that is poverty due to the failure of the family to use its

[1] B. Seebohm Rowntree & G. R. Lavers, *Poverty and the Welfare State*, pp. 39–40.
[2] P.E.P., 'Poverty, Ten Years after Beveridge', *Planning*, Volume XIX, No. 344, 4th August 1952.

resources with reasonable care and foresight, so that money is squandered on unessentials while the rent falls into arrears and the children are undernourished and ill-clad. Such conditions cannot be dealt with by financial aid alone; intensive social care and education, such as is described later in the book, must also be provided for these families.

CHAPTER IV

THE DEVELOPMENT OF THE HEALTH SERVICES

'An immortal work, since man cannot more nearly imitate the Deity than in bestowing health.'—*Inscription on the stone erected to the memory of Sir Hugh Middleton, who in the reign of James I brought a fresh supply of clean water to London.*

ON 5th July 1948 the National Health Service Act, an Act 'to promote . . . a comprehensive health service designed to secure improvement in the physical and mental health of the people of England and Wales, and the prevention, diagnosis, and treatment of illness'[1] became operative. It was just a hundred years since that Parliament, by passing the Public Health Act of 1848, had first affirmed the State's responsibility for securing minimum conditions of health for the people, and a comparison between the scope and character of the two measures brings out the advances in technique and changes in outlook of the intervening century.

The National Health Service Act, 1946, sets out to co-ordinate the personal health services and establish them on a national basis, and deals with such questions as medical treatment, at home and in hospital, health care for mothers and children, the provision of drugs and appliances and the setting up of health centres. It takes for granted the existence of a central government department which can take responsibility for the service as a whole, an ordered and reasonably efficient system of local government, and of measures to ensure a sufficiently healthy environment, such as a good supply of clean water, an efficient method of sewage disposal and of cleansing and draining the streets. These prerequisites of the personal health services, the pride of the twentieth century, were created by the sanitary reformers of the nineteenth, and their labours not only helped to make life in the great towns, brought into existence by the Industrial Revolution, tolerable, but probably saved the developing urban civilisation from being ravaged, and possibly destroyed, by infectious disease.

Some idea of the magnitude and complexity of the tasks which confronted Edwin Chadwick, Southwood Smith, their colleagues and supporters, can be gained by reading the Report on the Sani-

[1] National Health Service Act, 1946, Section (1).

tary Conditions of the Labouring Population of Great Britain, published in 1842, and other contemporary documents.[1] Not only had they to tackle the vast technical problems involved in cleansing, sewering, paving, and lighting the towns, for sanitary engineering was still in the experimental stage, but also to contend with the inefficiency and apathy of many of the local authorities,[2] and the chaotic state of local government, particularly in the areas outside the incorporated boroughs which were not affected by the Municipal Corporations Act of 1835, and further to face active opposition on the part of the many vested interests, concerned to preserve the *status quo*. The main need was for the establishment of efficient administrative machinery, both centrally and locally; a central body which would inspire, encourage, advise and, if necessary, coerce the responsible local authorities into an efficient discharge of their duties; and local bodies which would be responsible for all the sanitary services within their respective areas.

The first attempt to create this administrative framework by the establishment of a General and Local Boards of Health was ill-conceived and unsuccessful,[3] and the subsequent reaction probably delayed the development of the public health services for a number of years, but even after the abolition of the General Board of Health and the retirement of Chadwick, statesmen and administrators were not allowed to repudiate entirely the responsibility for the health of the nation they had reluctantly and half-heartedly assumed in 1848. Recurrent outbreaks of cholera; the patient work and example of Medical Officers of Health, of whom Sir John Simon, was the greatest,[4] and of statisticians such as Dr.

[1] Extracts are given in most social histories of the period, e.g., J. L. and Barbara Hammond, *The Bleak Age*, chs. iv and vii.

[2] Not all, however. Some were in advance of the general standards of the time, and used what powers they had to improve the sanitary conditions in their areas. For example, Liverpool, after obtaining a special Act giving it what were for the period drastic powers, appointed the first Medical Officer of Health in the country in 1847, and a Borough Surveyor and Inspector of Nuisances at the same time.

[3] The General Board of Health was controlled by a nominated President who was not necessarily a Minister of the Crown. Under certain circumstances it could turn a Town Council into a Board of Health against its will and yet it had no powers to appoint its own permanent inspectors. Sanitary measures which were urgently needed were carried out in different parts of the country as a result of the passing of the Act and the work of the Board, but its bias towards centralisation and Chadwick's tactlessness roused so much antagonism that in 1854 the Board was reconstituted (without Chadwick), and its medical duties were transferred to the Privy Council in 1858.

[4] For some years he was Medical Officer of Health to the City of London, he then became attached to the General Board of Health, and for fourteen years was Medical Officer to the Privy Council. His reports to the Privy Council, and his book *English Sanitary Institutions* are classics.

William Farr;[1] the work of Florence Nightingale both in insisting on sanitary reforms in the army and establishing nursing as a profession for educated women; and the increasing efficiency and enterprise of local authorities, together with advances in medical knowledge as to the cause and prevention of disease, all combined to keep the issue alive. As a result of all these efforts successive measures, culminating in the comprehensive Public Health Act of 1875, at length established the environmental health services on a firm basis. Even this Act did not satisfactorily solve the problem of central government administration, however, as it combined public health and Poor Law administration in the Local Government Board, and the spirit of the Poor Law was dominant for many years. It was not until the close of the First World War that the Ministry of Health was created and Chadwick's main task completed.

However, by the end of the nineteenth century the State had accepted responsibility for ensuring a reasonably healthy environment for its citizens both at home and, through the factory legislation whose growth had paralleled that of the public health services, at work. The foundations had been laid and reformers could begin the building of a superstructure of personal services, designed not only to maintain, but to improve, the health of the nation. It was already recognised that this largely depended on the health care of the mothers and children, and when once the most urgent problems of sanitation and the control of infectious disease had been met, those concerned with public health could turn their attention to the special needs of these groups. Voluntary organisations, such as the Manchester and Salford Ladies' Sanitary Reform Association, which established the first health visiting service in the country, and progressive Medical Officers of Health, such as Dr. F. Drew Harris of St. Helens, who established the first infant milk depot, and Dr. James Kerr of Bradford, who was inspecting school children and experimenting with a school clinic in the nineties, had already pioneered in this field, and their experience was invaluable to later legislators and administrators. By the first decade of the twentieth century the time was ripe for government action to secure an improvement in the national standard of physical efficiency, and public opinion, shocked by the revelations as to the number of army recruits rejected on grounds of physical unfitness during the South African War, was ready to accept it.

[1] Appointed Compiler of Abstracts to the General Register Office 1839, retired 1879. He has been described as 'the greatest medical statistician who has ever lived'. 'But for the work of Farr, the efforts of the sanitary reformers would have lacked direction and it would have been impossible to assess the value of the successive steps taken during the second half of the nineteenth century to reduce mortality.' W. M. Frazer, *History of English Public Health, 1834–1939*, p. 22.

The first personal health legislation passed was designed to minimise the risks of child-bearing by securing that only properly trained and qualified individuals should 'habitually and for gain' attend women in child-birth. This was accomplished by the Midwives Act, 1902, which, by the creation of the Central Midwives Board to be an examining and supervising body, and by directing that after 1905 no woman could enter the profession unless certified and registered, established a minimum standard of professional efficiency. In general, midwives remained independent private practitioners, however, and it was not until 1936 that local authorities were made responsible for ensuring that there was an adequate number of trained midwives practising in their respective areas and available when required. They could do this either by employing them themselves or coming to an agreement for their services with a voluntary organisation such as the local District Nursing Association. In this way domiciliary midwifery became in the main a public service under local authority control, one advantage of which was the possibility of closer association between the midwife and those responsible for the ante-natal and post-natal supervision of the mother, and the welfare of the infant, provisions for which had been increasing since the beginning of the century.

The objects of the maternity and child welfare service are the maintenance and improvement of the health of both mother and child. Although certain forms of treatment are available, for instance dental treatment for the mother, and the treatment of minor ailments in the child, the service is principally concerned with preventive measures and health education. It provides for the medical supervision of the mother before and after the birth of the child and for the regular examination of the infant at a clinic or centre; the visiting of mother and child at home by a properly trained and qualified health visitor, and the meeting of the special food requirements of the expectant and nursing mother and young child. Its slow but steady growth was due in large measure to both voluntary effort, to the enterprise and persistence of local Medical Officers of Health and to encouragement from enlightened administrators at the centre, particularly Sir Arthur Newsholme, who, when he became Medical Officer of the Local Government Board in 1908, made a special study of the nation's infant mortality rate and did all in his power to reduce it.[1] The First World War was followed by an increased recognition of the value of maternity and child welfare work, and the need for its establishment on a national basis, and the Maternity and Child Welfare Act, 1918

[1] The history of the maternity and child welfare services is told by Dr. G. F. McCleary, *Maternity and Child Welfare Movement*, 1935.

empowered local authorities to make arrangements for safeguarding the health of expectant mothers and children under five. Central Government grants were made available to assist the local authorities in this task, but the Act laid it down that the authorities who undertook it should appoint special Maternity and Child Welfare Committees—with at least two women members—to carry it out.

A necessary prerequisite of the efficient care of mother and child is that all births shall be notified to the local Medical Officer of Health, and since 1915 this has been compulsory throughout the country.

The legislation just described stimulated local authorities to develop their maternity and child welfare work, and in spite of certain shortcomings it has become widely recognised as one of the most valuable of the health and social services.[1]

The spectre of physical deterioration which haunted men in the early years of the twentieth century, and whose role in the development of the personal health services can be compared with that played by the recurrent outbreaks of cholera in reconciling people to the limitations imposed on them in the interests of sanitation in the first part of the nineteenth, was a precipitating factor in the enactment of legislation to ensure the physical well-being of school children. The need for such action had long been apparent to those in direct contact with the schools in the poorer areas, for the physical condition of many of the children compelled to attend school by the Education Acts of the closing years of the nineteenth century was such that they could have received little benefit from the instruction they were given. They came to school ill-nourished, dirty, insufficiently clad and often suffering from preventible defects, as much in need of medical attention and social care as instruction.

Efforts to meet these needs were made by enlightened School Boards, such as that at Bradford, by voluntary bodies, and sometimes by the teachers themselves, but the State took no action until after the publication of the Report of the Interdepartmental Committee on Physical Deterioration in 1904. This Committee's recommendations included the feeding of necessitous school children and school medical inspection, and these recommendations were carried into effect by the Education (Provision of Meals) Act, 1906, and the Education (Administrative Provisions) Act, 1907. The first of these Acts empowered local authorities to provide meals for necessitous children, while the latter made medical inspection a duty, and treatment permissive. From the time of their inception,

[1] The maternity and child welfare and related services are discussed in more detail in Chapter X below.

these provisions for preserving and improving the health of school children have been recognised as part of the nation's educational service. Legislative enactments under which they operate to-day are to be found, not in the National Health Service Act, 1946, but in the Education Act, 1944,[1] and the National Health Service Act is silent on the subject of the health of the school child. The acceptance in principle of a comprehensive national health service has, however, inevitably raised the question of the transfer of the school health services in whole or in part from the control of the education authorities and their incorporation into a general health service. Thus the White Paper in which the National Government of the war years set out its proposals for a National Health Service suggests that while inspection should remain a function of the Local Education Authority, 'as from the time when the new health service is able to take over its comprehensive care of health, the child will look for its treatment to the organisation which that service provides—and the education authority, as such, will give up responsibility for medical treatment'.[2] Full consideration of this issue involves an examination of the basis of social service administration, since here the desirability of unifying the health services clashes with the ideal of unifying the services for children and young people. The present arrangements, by which close co-operation between the Ministry of Education and the Ministry of Health and the local Health and Education Authorities is ensured, would seem a satisfactory compromise, at least until the pattern of both the health and the children's services, and indeed of local government itself, emerges from the melting-pot of their post-war reconstruction.

So far this chapter has been devoted to the consideration of the development of the services which are designed to safeguard the health of the people, and aim at improvements in general standards of health and well-being rather than the care or treatment of the sick. But the treatment of the sick, whether at home or in hospital, is now also recognised as a public responsibility, an integral part of any comprehensive health service, and the historical background of this modern assumption must now be considered.

Before 1911 the relationship between doctor and patient was for the great majority of people a matter of personal arrangement at private cost. The Poor Law Medical Service met the needs of those who would otherwise be destitute of medical care, but the

[1] Section 48. They are discussed in detail in Chapter XI below.

[2] Ministry of Health and Department of Health for Scotland, *A National Health Service*. Cmd. 6502/44, p. 39. This has actually taken place in some measure since the coming into force of the National Health Service Act. See below, Chapters XI and XII.

remainder of the population made their own arrangements with whichever doctor they had chosen, or whose services they had been able to obtain. The State gave powerful assistance to the medical profession in its efforts to maintain and raise its own standards, by prohibiting practitioners not on the Medical Register kept by the General Medical Council from signing death certificates, suing for payments or getting their prescriptions made up by chemists, but it left undisturbed the independent status of the general practitioner, who obtained the fees for his services in his own way as best he could. This frequently entailed some hardship both to the weekly wage-earner living on the margin of poverty and to those doctors who practised in working-class areas. Some doctors employed collectors on a commission basis to call weekly on those families who could not manage to pay the fee in a lump sum, while the more provident workers formed themselves into medical clubs or joined friendly societies, subscribing a few pence each week to be sure of being able to receive medical attention during sickness, without incurring debt. Dispensaries set up by the charitable in some of the large cities catered for the very poor, who also crowded into the out-patient departments of the hospitals, particularly in London, and hindered them from carrying out their proper work of specialised diagnosis and treatment.

A radical change took place when Mr. Lloyd George's National Health Insurance Act was placed on the statute book in 1911. This Act entitled insured persons not only to weekly payments to help maintain a minimum income level during sickness, but also to free doctoring from the doctor of their choice, provided he was among those who had agreed to participate in the scheme. The doctors were paid on a *per capita* basis. The 'panel doctor' was thus brought into being, and as the scope of National Health Insurance was extended, an increasing proportion of the population became his patients.

National Health Insurance had advantages for both doctor and patient. The doctor was assured of regular payments on behalf of his panel patients, and thus could count on a fairly stable nucleus income, while the wage-earner knew that if he fell ill he would not be burdened with a doctor's bill in addition to his loss of earnings and his other expenses. There were, however, limitations to the usefulness of the scheme. For example, it was confined to the insured workers themselves, and did not cover their dependants, a limitation which bore particularly hardly on the wives of the lower-paid workers. These women, often ignorant and prejudiced, overburdened with the task of meeting the needs of their families with inadequate resources, and creating some sort of a home in spite of deplorable housing conditions, sure that the whole structure of

home and family would collapse if they were laid up or sent to hospital, were still further discouraged from seeking medical advice by the knowledge that it must be paid for out of the house-keeping money, already strained to its limits.[1] Others excluded from the benefits of free doctoring were the small traders and independent workers, often as badly, if not worse, off than the insured worker.

While National Health Insurance eased the financial difficulties of the doctor striving to establish himself in private practice, it could not and did not provide a solution to other problems of which he and the public became increasingly conscious as time went on, and standards of medical treatment for the whole population were raised. Thus he remained an isolated unit, often chronically overworked and overstrained yet unable to take time off to obtain adequate holidays owing to the difficulties of finding and paying for a locum. He had great difficulty in finding the time to keep abreast with contemporary advances in scientific and medical thought and practice, and usually worked in his own home without the equipment and auxiliary staff which would render his task easier, and enable him to perform it more efficiently and increase the scope of his work. Moreover, not only were the conditions under which individual general practitioners were working unsatisfactory, but their distribution throughout the country was in no way related to the need for their services, so that, for instance, just before the war Hastings had one general practitioner for every 1,178 persons, in South Shields there was one for every 4,105. Yet, in spite of all these difficulties, and of the inroads of the growing public health and specialist provisions, the importance of the service rendered by the general practitioner—ideally not only 'a specialist in primary diagnosis giving first line treatment of all kinds', but also the health adviser of the families who chose to make him their confidant[2]—was increasingly recognised as vital, and when, after the publication of the Beveridge Plan, the idea of a comprehensive medical service for all citizens began to take shape it was clear that one of its objects must be to ensure that these services would be available for all the families of the nation.

Skilled medical attention is the first essential in sickness, but it

[1] This is discussed at some length by Margery Spring-Rice in *Working-class Wives* (a survey of the conditions of 1,250 married women based on information collected by the Women's Health Enquiry Committee), 1939, ch. iv. She quotes a letter from a district nurse in a rural area, part of which runs 'Fathers and children at work come under the N.H.I., but very seldom the mothers. It is the mother who gets left out as far as treatment goes. . . . She may get the family doctor for herself as well as the children if she is on the club. . . . If she does not pay in she carries on as long as she possibly can without advice or treatment. . . . She will not start a doctor's bill for herself if she can possibly stand on her feet.

[2] P.E.P., 'Medical Care for Citizens', *Planning*, No. 222, June 1944, p. 8.

has oft-times been rendered ineffective by lack of proper nursing care. Among the first to realise this, and to appreciate the difficulties that the poor and ignorant had in providing it in their own homes, was William Rathbone, a Liverpool merchant who, in 1859, started a system of district nursing by trained nurses in his native city. The success of this experiment led to its being adopted in both towns and cities throughout the land, and before long the district nurse became an established institution. Her work has been particularly valuable in rural areas where other medical and social services are scanty or wanting, and as the personal health services developed, the most practical and economical way of extending them to those areas where the population was too scattered to justify separate provision, was found to be by enlisting the co-operation of the local District Nursing Association, and extending the scope of the nurse's work. Consequently, in many areas she became health visitor, midwife, child-life protection visitor, tuberculosis visitor and school nurse, as well as attending to the sick. Moreover, a wise and sympathetic nurse is, in time, accepted as adviser and friend on all family and personal problems, a travelling Citizens' Advice Bureau, as well as a travelling clinic.[1]

As time went on it was recognised that hospital training was an inadequate preparation for the multifarious demands made on the district nurse, and the Queen's Institute of District Nursing[2] was established to co-ordinate the work of the separate voluntary committees in the different districts and to ensure that a good standard of nursing was maintained, and it arranges short training courses for those nurses who wish to take up this branch of the profession.

Skilled medical diagnosis and treatment and nursing care in the patient's own home together form the basis of medical care, but they are insufficient in themselves for the successful treatment of many conditions. These require the specialist skills and equipment which only a hospital can give, and which it is now its function to provide. From being 'asylums' for the sick poor the hospitals have changed and developed into centres where the resources of medical science are concentrated, to be expended freely for the benefit of the patient whatever his status in the world outside, and of recent years this spirit has penetrated even to those last refuges of the pre-

[1] 'It is wonderful how one finds out, and without asking, their joys and troubles, all their aches and pains, all their hopes and family histories. They expect advice about baby's rash, what to do with granny, father's false teeth, Johnny's boots . . . Lily's love affairs . . . and so on.'—Letter from district nurse quoted above.

[2] This originated as the Queen Victoria Jubilee Institute for Nurses, the founding of which was made possible by the decision of Queen Victoria to devote the money which the women of the nation collected to celebrate her Jubilee in 1887 to the purpose. The name was changed in 1925.

scientific era, the 'chronic' wards, now being transformed into geriatic units.[1] These developments have inevitably affected and been affected by methods of administration, and during the years before the recent war two questions which exercised the minds of many concerned administrators were how far existing methods were adequate to meet the needs of the developing situation, and along what lines changes should be made.

At that time there were two distinct hospital systems, the voluntary and the municipal, separately and differently organised and financed, and each with its own traditions and fund of experience. The voluntary hospitals, some of which, like St. Thomas's and St. Bartholomew's, could trace their history back to the Middle Ages, were independent organisations administered by their own governing bodies or boards of trustees. They varied greatly in size and efficiency, from the large general hospitals of 200 or more beds in London and the big cities with their distinguished consultants and modern equipment, to the small 'cottage hospitals' served by local general practitioners.[2] There was also considerable variation in function as, while the majority were general hospitals accepting a wide range of surgical and medical cases, others specialised in particular diseases or conditions. In general, however, the voluntary hospitals tended to accept only acute cases needing active treatment, leaving to the municipal hospitals the care of the chronic sick.

Municipal hospitals, for which the local authorities were directly responsible, were of two kinds, the infectious diseases hospitals and the general hospitals. The latter had originated as Poor Law Infirmaries, provided by the Boards of Guardians, for the 'destitute sick'. In many such infirmaries standards of care were, in the first instance, very low, but conditions improved after the middle of the century when 'Nightingale' nurses took the place of the able-bodied paupers who had hitherto 'nursed' their fellows,[3] and enlightened administrators gradually placed more emphasis on the noun 'sick' than the adjective 'destitute'. Finally, in 1929, the twenty-year-old recommendations of the Royal Commission on the

[1] See below, Chapter XVII.

[2] Just before the war, of the 700 or so voluntary hospitals in England and Wales for which particulars were available, some 75 had more than 200 beds, 115 had 100 to 200 beds each, over 500 had less than 100 beds and more than half of these had less than 30. Ministry of Health, op. cit., p. 58.

[3] The first qualified nurse to be appointed to a Poor Law Infirmary was Agnes Jones, who, as a result of the efforts of the same William Rathbone who started district nursing in the city, was put in charge of the male wards of the Brownlow Hill Institution, Liverpool, in 1864. She compared the place as she found it to Dante's *Inferno*, but gradually brought about considerable improvements. Her devotion to duty undermined her health, and she died of typhus a few years after her appointment.

Poor Law were put into operation, the Boards of Guardians were abolished, and it became an accepted principle that 'general hospital care was a proper activity of the major local health authorities rather than of the Poor Law machinery'.[1] During the next few years local Health Committees gradually 'appropriated' the old infirmaries and began the slow and difficult process of converting them into modern hospitals. Although handicapped by unsuitable buildings and the Poor Law atmosphere, good progress was being made by many local authorities in the years immediately preceding the war. Some authorities not only modernised old hospitals, but built new ones, and at the outbreak of war many Health Committees had hospitals under their control of which they were justly proud.[2]

But while much good, and even invaluable, work was done in connection with both the voluntary and municipal hospital service, the position, taken as a whole, was far from satisfactory. 'Britain had hospitals, but no hospital system', and nobody had the power or responsibility to combine the separate units into a planned and co-ordinated service based on a consideration of the needs of all sections of the population.[3] Like doctors, hospitals were unevenly distributed, and in some areas the provision was inadequate for the needs of the population; many were too small for efficient working, and in many voluntary hospitals and some local authority areas finance presented a serious problem and held back improvements. The lack of co-ordination meant that there could be two hospitals in the same area close to each other, one in debt, the other well endowed, one with a long waiting list, the other with empty beds.

As medical science developed and standards of hospital care rose, the disadvantages of this lack of co-ordination and administractive inefficiency became more and more evident, and the need for closer co-operation was increasingly recognised. The King Edward Hospital Fund for London started in 1897 by Edward VII when Prince of Wales as the Prince of Wales Hospital Fund was the first step in this direction. But it only touched the fringe of the problem. Many years later the voluntary hospitals in certain provincial cities, such as Liverpool and Bristol, took the much bolder step of forming themselves into hospital units, and the possibility

[1] Ministry of Health, op. cit., p. 56.

[2] Just before the war the local authorities of England and Wales had nearly 70,000 beds in 140 general hospitals maintained by public health committees, and nearly 60,000 more in 400 hospitals and institutions still administered under the Poor Law by public assistance committees.

[3] Cf. P.E.P., *Planning*, No. 222, June 1944, 'Medical Care for Citizens', p. 41, and Ministry of Health, op. cit., p. 56, where the hospital services are described as 'everybody's business, but nobody's full responsibility'.

and desirability of regional co-operation began to be seriously considered. Then came the war, and the prospect of many casualties, both from the battle zones and as a result of air raids, made planning on a national scale essential. So the Emergency Medical Service came into being, and brought with it improvements in many hospitals, but 'above all experience of what it means to translate a collection of individual hospitals into a related hospital system'.[1] This having been achieved a return to the previous inchoate state of affairs was unthinkable, and the creation of a national hospital service was clearly the next step forward.

Thus, as with social insurance and assistance, so with provisions for medical care; the time was ripe for the creation of a unified national service based on the varied developments of the previous half-century, and in February 1944 the National Government published a White Paper outlining its proposals for a comprehensive service which would 'bring the country's full resources to bear on reducing the ill-health and promoting the good health of its citizens,[2] and which would ensure that in future every man, woman and child in the country could rely on getting the advice and treatment needed in matters of personal health, irrespective of ability to pay. The proposals contained in the White Paper had not yet been given legislative form and passed through Parliament when the general election of 1945 took place, and the Labour Government took over this task. Mr. Aneurin Bevan, who became Minister of Health, made several changes in the White Paper proposals, but the underlying purpose remained the same, and in November 1946, after eighteen months of negotiation and controversy, the National Health Service Act, 'to provide for the establishment of a comprehensive health service for the people of England and Wales', was placed on the statute book.

[1] Ministry of Health, op. cit., p. 7. For a discussion of the working of this scheme see R. M. Titmuss, *Problems of Social Policy*. The scope and quality of the service are assessed in ch. xxiii, pp. 466–89. The following chapter, ch. xxiv, deals with the effect of the war on hospitals for the sick.

[2] Ministry of Health, op. cit., p. 5.

CHAPTER V

THE NATIONAL HEALTH SERVICE

THE object of the National Health Service Act, 1946, was to create an administrative framework within which a health service universal in scope, comprehensive in character and for the most part free to the user could be built up. These broad aims are generally accepted, but the methods by which they are sought have been subject to a good deal of criticism. This is not altogether surprising considering the intricacy of the problems, both technical and social, to be solved, the sharp divergencies of opinion as to the best means of solving them, and the numerous interests affected.

A noticeable feature of the new health service is its comprehensiveness, for with two exceptions it embraces all forms of personal health and medical care. The two exceptions are the health care of the school child, and the health care of the worker. As we have seen the health care of the school child remains, in the main, the responsibility of the Local Education Authorities,[1] but since the National Health Service Act came into force they have been relieved of financial responsibility for the hospital treatment of school children, and are enabled to make arrangements with the Regional Hospital Boards for the latter to become responsible for consultative and specialist work in the school clinics.[2]

What legislative provisions there are for safeguarding and improving the health of the worker are contained in the Factories Acts of 1937 and 1948 and their attendant regulations. These insist that factories and workshops shall be reasonably clean, light, warm and well ventilated, that the hours worked by women and young persons shall not be excessive, and that proper precautions shall be taken to ensure the safety of the workers. For many years now young persons under sixteen entering industry have been subject to a medical examination, and the Factories Act of 1937 contains provisions which make it more effective, while the Act of 1948 brings all young persons under the age of eighteen within its scope, and provides for re-examination at yearly intervals.[3] Many large in-

[1] This service is discussed in more detail in Chapter XI.

[2] Ministry of Education, *Education in 1948*, Cmd. 7724, p. 71.

[3] The welfare of the young worker is discussed in more detail below, Chapter XV.

dustrial firms go much further in their health and welfare provisions than is required by law, and provide extensive medical services, while the importance of industrial medicine and research into problems of industrial health is becoming more widely recognised.[1]

If the National Health Service Act falls short of complete comprehensiveness in these two respects, there is little else it leaves out. All forms of medical care and treatment are included, the powers of the local authorities to do positive and preventive work are strengthened and widened, while one of the notable features of the Act is the specific inclusion of mental health within its scope. This reflects the modern attitude towards the problems of mental disease and mental defect, an outlook which stresses prevention and treatment rather than protective custody, and seeks to minimise the shame and dread with which these conditions are regarded.[2]

The administrative structure of the National Health Service is inevitably complicated. The conditions necessary for the efficient functioning of the different services provided vary widely, and consideration had also to be given to the wishes of those who were to operate them. Ultimate control rests with the Minister of Health. He is, of course, responsible to Parliament, and thus to the people, but within the framework of the Act his powers are very considerable. However, in common with other recent social legislation[3] the Act creates an advisory body—the Central Health Services Council,—to advise him on professional and technical questions. The forty-one members of this Council are either members of the medical and kindred professions or people with special experience in local government, hospital management or mental health. With the exception of the holders of certain specified offices, such as the President of the Royal College of Surgeons, members are appointed by the Minister after consultation with the relevant professional bodies. The Council's functions are purely advisory, and the Minister is not bound to take its advice, but he is required by the Act to lay its annual report before Parliament,[4] and in this

[1] See Report of a Committee of Enquiry on Industrial Health Services. Cmd. 8170, H.M.S.O., 1951.

[2] This question is discussed in more detail in Chapter XIX below.

[3] E.g., the Children Act, 1948, makes provision for a Central Advisory Council in Child Care, while the Minister of Education has been provided by the Education Act, 1944, with two Advisory Councils, one for England and one for Wales and Monmouthshire.

[4] The National Health Service Act, 1946, Section 2 (5). The Minister may refrain from publishing anything in the Report if, after consulting with the Council, he is satisfied that it would be contrary to the public interest. This is a normal legal safeguard.

way the views of the Council become known, even if they differ from those of the Minister. The Act also makes provision for standing advisory committees on special questions, and nine such committees have been established.[1] Both the annual reports of the Council and the special reports issued from time to time by its committees contain useful proposals on major issues of policy as well as descriptions of present conditions and work done.[2]

The services provided under the National Health Service Act are administered in three separate groups, the Hospital and Specialist Services, the Personal Practitioner Services and the Local Authority Services. The Hospital and Specialist Services include all forms of general and special hospital provision both in-patient and out-patient, and specialist advice either in hospital, at a health centre, or, if required, at the patient's own home. These services are directly under the control of the Ministry of Health, and are organised regionally, the country being divided for the purpose into fourteen Hospital Regions, centred round cities with university medical schools. The Regional Hospital Boards are responsible for the general planning and co-ordination of the hospital services in their respective regions. They decide major issues of policy, but the day-to-day administration of the hospitals is in the hands of Hospital Management Committees, each of which is responsible, as an agent of its Board, for a group of hospitals. The teaching hospitals, that is hospitals linked with university medical schools, are outside the scope of the Regional Boards and retain their own governing bodies, but they are, and must be, an essential part of the hospital service of the region in which they are situated.

The desirability of some form of regional hospital organisation has been recognised for many years, and *The Practitioner* in its review of the first year's working of the Act records that its introduction gave general satisfaction to the medical profession, and its advantages from the point of view of the efficient planning of specialist services quickly became manifest.[3] The method of administration adopted has been criticised, however, on the grounds that it is both undemocratic and impersonal, since the local hospital, in which the inhabitants of the district may have taken both pride and interest, loses its identity and becomes a relatively unimportant unit in a vast organisation. Those who criticise the new hospital service on these grounds fear lest regional organisa-

[1] Medical, Dental, Pharmaceutical, Ophthalmic, Nursing, Maternity and Midwifery, Mental Health, Tuberculosis, Cancer and Radiotherapy.

[2] E.g. Report of the Committee on General Practice within the N.H.S.

[3] *The National Health Service Act in Great Britain, a Review of the First Year's Working*, p. 5.

tion and control, at least as now established, will result in bureaucratic and mechanical administration and the consequent sacrifice of the interests and feelings of the patient as a person to a rigid conception of efficiency. Such tendencies are inherent in any large-scale organisation, but it would seem as though the Ministry of Health were aware of them and seeking to mitigate them. Thus, as already mentioned, the hospitals within each region are divided into groups, either on a geographical or functional basis, each group with its own Management Committee, while House Committees may also be established in connection with individual hospitals. In this way it is hoped that people formerly concerned to further the well-being of staff and patients in particular hospitals will still be able to maintain a personal interest in them, and thus will help to preserve the identities of the different hospitals, while at the same time encouraging the growth of group consciousness and loyalty.[1] Further, it has been the policy of the Ministry to make the membership of both the Regional Boards and the Management Committees as widely representative as possible.[2]

These efforts to maintain local interest are all to the good, but do not meet the major criticism that the whole service is undemocratic, since it is organised from above, in that the Boards are agents of the Ministry, the Hospital Management Committees of the Boards. Since hospital regions do not coincide with present local authority areas, it is difficult to see how a satisfactory method of direct election to Regional Boards could be devised, and this problem may not be capable of a democratic solution unless and until local government is reorganised on a regional basis. Moreover, it is arguable that, by keeping the power of selection in his own hands, the Minister is able to secure a fair distribution of seats on the Regional Boards and Management Committees between the various interested bodies, and at the same time select as members people who have a special contribution to make to the hospital services. This is the crux of the matter, for in the long run the departure from democratic principle involved in the present constitution of the Regional Hospital Boards and Management Committees can only be justified if, in fact, 'nomination from above can secure better people and more balanced committees without sacrificing that responsiveness to public needs and opinion which is or should be the mark of the elected representative'.[3]

During the first years of their existence a good deal of the time and energy of the Regional Hospital Boards has necessarily been

[1] Cf. 11th Report of the Select Committee on Estimates, p. 19.
[2] Ministry of Health, *The National Health Service*, p. 5.
[3] P.E.P., 'The Hospital Service. I. System of Management', *Planning*, Vol. XVI, No. 303, September 1949.

taken up with getting the complicated administrative machinery of this part of the service into working order. But, apart from this, they have many serious difficulties to contend with, and there is much constructive work to be done before Britain can lay claim to a really first-class hospital service. Nationalisation in itself will not perform miracles and modernise obsolete hospital buildings, build new hospitals and provide new and up-to-date equipment overnight. It merely makes it more possible for that proportion of the resources of the community which is available for these purposes to be rationally used and wisely distributed. The creation of a really adequate service of which the country can be proud will be a slow and difficult process, particularly in view of the present economic situation which has already entailed some cuts in expenditure.

One of the most urgent of the difficulties which the hospital service has to meet is the shortage of nurses, and the seriousness of this shortage led the Ministry to appoint a Working Party to consider their recruitment and training. The report which this Working Party issued in 1947 considered that, while the shortage might be attributed in part to increased demand rather than a decline in the supply of recruits,[1] the key problem is that of wastage during training[2] and it stressed that if this was to be avoided 'Nurses in training must no longer be regarded as junior employees subject to an outworn system of discipline, they must be accorded full student status as far as the intrinsic requirements of nurse training permit'.[3] This would enable a comprehensive and effective training to be given in two years, eighteen months of which would be devoted to the fundamentals of nursing, the remainder to concentrated training in a chosen field. This training should, the Working Party considered, be followed by a year's supervised practical experience before full nursing status be accorded. The Committee recommended further that hospitals and public health agencies in each region should be grouped into composite training units, whose work would be co-ordinated by a Regional Nurse Training Board.

One member of the Working Party, Dr. John Cohen, did not

[1] Report of the Working Party on the Recruitment and Training of Nurses, 1947, p. 5. The total nursing force increased by over 15,000 between 1938 and 1945, but the number of *trained* nurses in active employment declined slightly over the same period. At the same time the demand for nurses increased.

[2] This is brought out by a survey, 'Employment Relations in a Group of Hospitals' (the Central Wirral Group), made by the University of Liverpool Department of Social Science in 1950. It was estimated as a result of the information obtained that 50 per cent of the nursing trainees had left by the end of the first year.

[3] Op. cit., summary of the main conclusions, p. 78.

sign the Report as he felt that there was a fundamental divergence of views between himself and his colleagues as to the nature of the problem. His Minority Report stresses the need for social and psychological research to determine the true nursing needs of the community. These, he argued, can only be assessed within the framework of a planned health service, and the assessment must be based on research 'on a scale commensurate with the needs of the national situation' which should include a study to determine the optimum diversion of effort between the curative and preventive services, including the claims of different types of nursing. The function of the nurse is defined as being 'the reduction in the incidence and duration of illness', and the selection of candidates for the profession, and the content, methods and duration of their training should be directed to fitting them to discharge this function properly. Dr. Cohen appears to approve of some of the practical proposals of his colleagues, for example that domestic and repetitive work during training should be minimised. He considers that if this were done, the present training might be reduced to two years. He also considers that hospital discipline should be humanised, and makes suggestions as to measures which might be taken to accomplish this, but throughout his recommendations he stresses that the real need is for further research into the means of improving the effectiveness of the nursing service as measured by some objective criterion such as the duration of the patient's sickness.[1]

The Nurses Act, 1949, provides for the reorganisation of the training of nurses along the lines suggested by the Majority Report. The General Nursing Council for England and Wales, which remains responsible for the training and registration of nurses, is reconstituted, and given powers to experiment in new methods of training and examination without prejudice to the status of the nurses so trained.[2] A Nurse Training Committee is to be set up in each hospital region, and the expenditure incurred by Hospital Management Committees or Governors of teaching hospitals in the training of nurses is to be defrayed by the Training Committee. These provisions make the student status of the nurse clear, and, provided that the General Nursing Council and the regional committees show imagination and initiative, experiments which will ultimately lead to higher standards of nursing care, and less frustration and wastage during training, should follow.

The personal, or as a recent leaflet issued by the Ministry of Health prefers to call them, the 'family' practitioner services, in-

[1] Op. cit., pp. 53–5.

[2] Nurses Act, 1949, Section 3. Experimental schemes are, however, subject to approval by the Minister.

clude the services of the general practitioner or family doctor, the dentist, the pharmacist, the ophthalmic doctor and the ophthalmic optician, and aim at providing medical and dental care for the whole population. The key position in this part of the service is occupied by the general practitioner, and his status and the conditions under which he works are therefore of great importance. The problem facing the planners of the service was to ensure that the services of a general practitioner would be available for the whole population, with the best possible conditions for both doctor and patient, and at the same time to preserve the doctor's clinical freedom, freedom of choice for both patient and doctor, and a satisfactory personal relationship between them. These last three conditions are regarded by the doctors as essential for the proper practice of their profession, and, rightly or wrongly, they believe that they would be endangered if medical practice became a salaried service directly under the control of the State or the local authorities.[1]

A compromise solution has been reached by the creation of what are called Local Executive Councils to administer this branch of the service. The Chairman and half the twenty-four members of each Council are appointed by the Ministry of Health and the Local Health Authorities, the remainder represent the professions providing the services. Doctors and dentists proposing to practise in a particular area contract with their Local Executive Council, which is responsible for their payment. General practitioners are paid from a central pool, and since 1952–3 have been remunerated in accordance with the Danckwerts award of March 1952, which determined the size of this pool, and the report of a Joint Working Party which considered a plan for its better distribution. The maximum number of patients allowed is now 3,500, whether for a single doctor or the average of a partnership, and the capitation fee has been adjusted so as to discourage unduly large lists, make it easier for new doctors to enter general practice and stimulate group practice. It is now approximately 17s. for all patients with an additional fee of 10s. for patients within the range 501–1,500. Provisions have been made for stimulating group practice and in designated areas Initial Practice Allowances are payable.

In order to secure a more even distribution of doctors two Medical Practices Committees, one for England and Wales and one for

[1] So afraid was the profession of the possibility of the gradual introduction of a salaried state medical service by means of ministerial regulation that it brought pressure to bear on the Minister to introduce legislation making it impossible. This was done by the National Health Service (Amendment) Act, 1949, Section 10.

Scotland, have been established, and their approval must be obtained before vacancies occurring in the general practitioner service in any area are filled. The powers of these Committees are, however, strictly limited and purely negative. They can refuse to allow a vacancy in an area considered to be over-doctored to be filled, but cannot direct a doctor to any particular area, however great the need there. As the Annual Report of the Ministry of Health for 1948–9 points out,[1] the gradual redistribution of medical man-power to meet the needs of the population, and relieve the pressure in those areas where doctors are seriously overworked, is something which the profession itself will have to achieve voluntarily over the years, and all the Medical Practices Committees can do is to facilitate this change.

Among the benefits to which the patient was entitled under the National Health Service Act, 1946, was the free provision of such drugs and appliances as were required for his treatment. This was regarded as a necessary part of any comprehensive medical service, but it was a provision open to abuse and there was a good deal of this, in some cases it would seem with the acquiescence of certain doctors who, pressed for time, have signed certificates without a thorough examination. In view of this abuse and of the rising cost of the National Health Service, Parliament has passed legislation[1] imposing a charge of 1s. on each prescription made out by a general practitioner. Moreover, with certain exceptions, the patient has now to contribute to the cost of such medical appliances as surgical boots. With the exception of young persons under 21, expectant mothers and mothers of children under a year old, patients must contribute up to £1 towards their dental treatment and both young and old pay up to 85s. towards the cost of dentures. Contributions to the cost of ophthalmic treatment and of spectacles must also be made. These measures appear to be having some deterrent effect, but there is still room for education in social responsibility in which doctors[4] and all who wish for the success of the health service can contribute.

In the previous chapter some of the difficulties of the general practitioner prior to the introduction of the National Health Service were discussed. These included isolation, unsuitable premises,

[1] Report of the Ministry of Health for the year ended 31st March 1949. Cmd. 7910, p. 123.

[2] Joseph S. Collings, 'General Practice in England To-day', *The Lancet*, 25th March 1950, p. 568.

[3] Discussed in more detail, p. 81.

[4] 'Whenever a doctor has had a practice for any length of time, and has exercised a reasonable educational and disciplinary function he is not the victim of patient abuse; the amount of this he suffers from is almost directly proportional to his laxity in these regards.' J. S. Collings, op. cit., p. 569.

lack of facilities for diagnosis, and in many instances, particularly in industrial areas, a volume of work so great as to make adequate diagnosis and real individual care impossible. The practitioner was thus often unable to fulfil properly either of the two roles assigned to him, that of family doctor, knownig his patients as persons and understanding something of their psychological and social as well as their medical needs, or that of the 'specialist in diagnosis'.[1] So far the National Health Service has brought little improvement in these respects; indeed, by extending free medical care to the whole population it has thrown a greater strain on the practitioner and intensified the already existing shortcomings of the system. This was brought home by a report on the General Practice and the Training of the General Practitioner issued in May 1950 by the British Medical Association, which stressed that if the general practitioner is to do his work properly he must have *time*—time to get to know his patients intimately, time for professional reading, attendance at post-graduate courses, perhaps research in connection with his practice. This means more doctors with fewer patients, and hence an increase in the cost of this branch of the service. In the long run this would undoubtedly be justified, as a really efficient personal practitioner service is essential to the working of the Act and the better health of the people.

The present difficulties in general practice are accentuated by the failure to provide the health centres which, it was hoped, would become 'a main feature of the personal practitioner service'.[2] In these centres, so the planners intended, group practice would be developed, scientific aids to diagnosis and facilities for minor surgery provided, and nurses, clinical assistants, and medical social workers would be in attendance. The doctor would thus be able to work underconditions that would allow him to give of his best without undue strain. It is true that some critics feared that practice in health centres would lack the personal touch which they believed characterised practice carried on in the doctor's own surgery,[3] but this does not necessarily follow since doctors practising in a health centre can still retain their own patients, only treating each other's in emergencies, and they would be expected to attend patients in their own homes whenever necessary.

[1] Cf. J. S. Collings, op. cit. Dr. Collings made his survey less than six months after the implementation of the National Health Service Act and endeavoured to make an assessment of general practice 'out of relation to the Act', before evaluating the effect of the Act upon it.

[2] National Health Service Bill, Summary of the Proposed New Service, Cmd. 6761, p. 9.

[3] E.g., House of Commons Debate on the Second Reading of the National Health Service Bill, speeches by Sir W. Wakefield, 2nd May 1946. Parliamentary Debates, Commons, Vol. CCCCXXII, col. 368; and by Mr. J. S. Reid, ibid., col. 390.

While one of the most important functions of health centres is intended to be the provision of proper accommodation for general practitioners, it is hoped that the larger centres, at any rate, will be more than group surgeries with adequate waiting-room and other ancillary accommodation. They are designed also to house local authority clinics and associated services, and thus bring together curative and preventive medicine under one roof, and, in time, become centres of health education. The task of providing health centres has been entrusted to the Local Health Authorities, and these are reserving space for them in their development plans, while enthusiasts are making blue-prints of the buildings which will one day occupy these sites. This day is likely to be far distant, however, as owing to shortages of labour and material and to the need for reducing capital expenditure to a minimum, the Minister is not encouraging their construction for the time being. From the point of view of the immediate efficiency of the health service this is most unfortunate, as the health centres occupy a key position in its structure, and the gap left by their absence imposes severe strains not only on the personal practitioner service, but on the hospitals, which are now treating relatively minor conditions which could be dealt with quite satisfactorily at an adequately equipped health centre. It has been suggested[1] that since large numbers of permanent structures are out of the question for the time being, temporary buildings, for example, prefabricated huts, might be erected for the purpose, and certainly such temporary buildings would provide opportunities for experimenting with different designs and arrangements, the results of which would be invaluable when permanent centres came to be built. Small-scale experiments are in any case desirable before the widespread construction of expensive permanent buildings, and the enforced delay might in this way be turned to good account.

Had it been possible for local authorities to proceed immediately with the designing, equipping and staffing of health centres this would have given them an important and creative role in the development of the health service, and provided a new outlet for the constructive abilities and civic pride of those councillors and officials who, until the implementation of the Act, had devoted their energies to raising the standards of their local hospitals, now transferred to the Regional Boards. As it is, while the powers of local authorities have been strengthened in some directions, and they can provide useful services, particularly in the fields of preventive medicine and community health care, their opportunities for really creative work are somewhat limited, and have, apart from the health centres, been curtailed rather than expanded.

[1] E.g. Report of the Central Health Services Council for 1950.

The Local Health Authorities for the purposes of the Act are the County Councils and the County Borough Councils, but Joint Boards may be established where it is considered expedient. Some decentralisation is possible in the county areas, since they may be sub-divided 'according to local health requirements', and sub-committees of the County Health Committee, on which the Councils of the County Districts in the sub-division are represented, set up in each area. These sub-committees undertake the day-to-day administration of the services delegated to them, but the County Council, as Local Health Authority, retains responsibility for general policy and finance.[1] Thus the National Health Service Act has given more power and responsibility to the major local authorities, relegating the smaller authorities to a subordinate position in a way characteristic of much modern social legislation.[2] This tendency may make for efficiency, but discounts local interest and knowledge, and the somewhat artificial attempts to find scope for these two ancient foundations of local government by such means as the Divisional Executives of the Education Act and the Area Sub-committees of the National Health Service Act are poor sub stitutes for the real thing. However, this is primarily a question of local government reform, and cannot be discussed at length here.[3]

Among the most important duties delegated to the Local Health Authorities by the National Health Service Act are those which seek to safeguard and improve the health of mothers and young children.[4] These duties include the care (including the dental care) of expectant and nursing mothers and of young children, the provision of an adequate number of midwives for the needs of the area, and of a complete health visitor service. Local Health Authorities are not the only statutory bodies made responsible for the care of mothers and children, however. They share this responsibility with the Regional Hospital Boards, which have taken over the maternity hospitals and associated consultant services, and with the Executive Councils which are responsible for the 'maternity medical services' carried out by general practitioners prepared to under-

[1] Ministry of Health Circular 118/47, *National Health Service Act, 1946. Health Services to be provided by Local Authorities under Part III of the Act*, par. 20, p. 8.

[2] Cf. the relevant provisions of the Education Act, 1944, the Town and Country Planning Act, 1947, the Children Act, 1948. All these Acts make the County Councils and the County Borough Councils the responsible local government units and combine to reduce the powers and importance of the smaller units.

[3] Cf. the comments made above, pp. 65, on the regional planning of the hospital service.

[4] These are laid down in Sections 21–4 of the Act. It has already been pointed out that the health care of school children remains the responsibility of the Local Education Authority.

take this work. These 'general practitioner obstetricians' receive special *per capita* fees from their Executive Councils for the supervision of maternity cases, such supervision to include at least two ante-natal and one post-natal examination, and attendance at the confinement, should the doctor consider it necessary or be summoned by the midwife in charge of the case.

The arrangements for maternity care established by the National Health Service Act and its attendant regulations have been severely criticised, mainly on the grounds that instead of creating a unified maternity service designed to give mother and child continuous care from the time when the pregnant woman notifies her pregnancy to the time when the infant has achieved a successful start in life, it has divided responsibility and control.[1] The Ministry regards this as unavoidable but is encouraging regional and local co-ordination.[2] Moreover, it has been found, in some areas at any rate, that the arrangements made for the care of the expectant mother by the Act have led to a falling-off in attendances at the local authority ante-natal clinics[3] since women who are to be confined in a hospital receive their ante-natal and post-natal care under its auspices (though this does not preclude the possibility of Local Health Authority clinics being regarded as outposts of the hospital for this purpose),[4] while women expecting to be confined at home rely on the general practitioner for supervision, since his services are now free. The tendency to ignore the services provided by the clinics under the impression that the two ante-natal examinations given by the doctor, supplemented perhaps by one or two consultations with the midwife, are all that are required, should be countered as far as possible, since in spite of the shortcomings due largely to unsuitable premises or shortage of staff from which many of them suffer,[5] these clinics provide valuable opportunities for health education and contacts with health visitors and midwives, as well as for medical supervision. In the future their role in the care of the expectant mother is likely to

[1] 'The Obstetrician and the Service', *The Practitioner*, op. cit., p. 25; cf. *Report of the Working Party on Midwives*, H.M.S.O., 1949, par. 104, p. 26, where the Working Party recommends that a Maternity Services Committee, including obstetricians, general practitioners and midwives, be set up.

[2] Report of the Ministry of Health for the year ended 31st March 1950, Cmd. 8342, p. 52.

[3] Report of the Ministry of Health for the year ended 31st March 1949, Cmd. 7910, p. 157.

[4] Ministry of Health Circular 118/47, par. 14, p. 5.

[5] For examples see *Maternity in Great Britain*, a Survey of Social and Economic Aspects of Pregnancy and Childbirth undertaken by a Joint Committee of the Royal College of Obstetricians and Gynaecologists and the Population Investigation Committee, pp. 39 ff. The findings of this committee are discussed in more detail in Chapter X.

be supplementary rather than central,[1] but with the co-operation of the general practitioners and the hospitals, it should be an important and useful one.

The concern that has been felt lest ante-natal care be concentrated in the hands of general practitioners to the detriment of the local authority clinics is paralleled by some anxiety lest the provisions of the National Health Service Act are having an adverse effect on the status and functions of the midwife. Historically, as the Working Party on Midwives points out,[2] the two professions of midwife and obstetrician have evolved side by side, but they have often been in competition with each other. During the nineteenth century the employment of a doctor to deliver one's child became one of the hall-marks of social superiority, and women debarred by poverty from this felt that they were missing something socially as well as medically. This attitude has masked what should be the real division of function between doctor and midwife, namely that while the doctor should be available to detect and treat abnormalities, the midwife should be recognised as 'the practitioner in normal midwifery, the expert in normal child-bearing in all its varied aspects'.[3]

The National Health Service Act, with its abolition of distinctions based on income, provided the opportunity of making this clear, and giving the midwife her proper place as an independent practitioner in the obstetrical team. Instead, however, although the vast majority of women are still delivered by midwives, there is some evidence that general practitioner obstetricians are taking over some of the formers' responsibilities and reducing their status to that of maternity nurses.[4] Such a tendency may have an adverse effect on the quality of the maternity service, partly because of its effect on the recruitment and skill of midwives, and partly because it emphasises the pathological aspects of childbirth. An understandable reason why many women prefer to be attended by a doctor is that they believe that in this way they are more likely to obtain relief from pain by the use of anaesthesia or analgesia, and any steps which are taken to increase the efficiency of analgesia and facilitate its use by midwives will increase women's willingness to accept their services.

For many years now the health visitor has been an active and valuable member of the maternity and child welfare team, her

[1] Annual Report of the Ministry of Health, 1948–9, p. 157, ch. iii.

[2] Op. cit., ch. iii. [3] Ibid., par. 102, p. 25.

[4] Ibid., cf. Postcript, p. viii, cf. 'The Obstetrician and the Service', *The Practitioner Review of the National Health Service Act*, pp. 25–7. In order to counteract this tendency the Ministry has issued a statement emphasising that in domiciliary midwifery the midwife should continue to be regarded as the normal attendant, but now has at hand, to assist if need be, a doctor who already knows the case.

speciality being the education of mothers in the care of their children. She visits mothers of young children in their homes, observes conditions and adapts her advice accordingly so that it is really appropriate to the needs of that particular mother and child. She also attends the infant welfare clinic and examines the babies, referring to the doctor any who are not making satisfactory progress; advises the mothers individually on infant feeding and general child hygiene and care, and perhaps gives informal group talks on these subjects. The help given by health visitors is generally appreciated, if their advice is not always followed, but in many areas there are not enough of them to provide the intensive supervision which some mothers need. The National Health Service Act extends the scope of their work, turning them, in intent at any rate, from maternity and child welfare workers to family health advisers, whose function it is to give advice 'as to the care of young children, persons suffering from illness, and expectant or nursing mothers, and as to measures necessary to prevent the spread of infection'.[1] Moreover, while hitherto she has worked on the staff of the Local Health Authority, and will continue to be employed by them, it is intended that in future the health visitor should be in much closer contact with the family doctor so that he can readily call on her when he finds a family needing health advice or social care which she can give or arrange.[2] If this indicates an increased appreciation of social factors in the causation and treatment of illness, and an attempt to bring about a closer link between curative medicine and health care, it is likely to have beneficial effects. Its implementation will, however, necessitate a considerable increase in the numbers of health visitors, and their training will have to be planned so as to give due emphasis to the social as well as the medical aspects of their work. This is necessary to enable the health visitor to appreciate the personal as well as the health problems of the families visited, see how they interact, and seek the help of the social worker best fitted to deal with them. The extension of the health visitor's functions envisaged by the Act would also seem to necessitate the education of the family doctor in the nature of her work and its possibilities. Closer co-operation between general practitioners and health visitors is recommended by the Central Health Services Council committee on General Practice. A Working Party on her training has been set up by the Minister of Health and other Ministers. For the present the available health visitors

[1] National Health Service Act, Section 24 (1), Ministry of Health Circular 118/47, par. 30, p. 10.

[2] Ministry of Health, *The National Health Service*, p. 3. If and where almoners are employed in connection with the personal practitioner service their functions will be complementary to and interlock with those of the health visitor. See below, Chapter VII.

are fully occupied with maternity and child welfare work, tuberculosis after-care, and other local authority responsibilities, and, taking the factors just discussed into consideration, these are likely to be their main spheres of work for some years to come.

The National Health Service Act gives Local Health Authorities wide powers to provide for the proper care of the sick who are being nursed in their own homes, and the after-care of those discharged from hospitals or institutions.[1] Thus each Local Health Authority must see to it that there is an adequate home nursing service in its area, either by providing one itself, or by making appropriate arrangements with a voluntary organisation. In many parts of the country, where District Nursing Associations have established a high standard of nursing care, Local Health Authorities have arranged for them to continue their work, but of course the service is now free to the user. Local Health Authorities are also empowered to continue the schemes whereby the District Nursing Associations lent such nursing requisites as air rings and bed cradles to their patients, and also to extend these facilities to cases to which the nurse has not been called as the patient is being wholly cared for by his relatives. This loan service is one of the few services provided under the Act which is not free to the user, for a small charge, scaled according to the income of the borrower, is made for each loan.

One of the most difficult problems associated with sickness, especially if it is the housewife who is ill, is the care of the home and family, and the problem may become chronic if she is incapacitated by old age or prolonged infirmity. Consequently, wherever home help services have been established they have been widely welcomed. The National Health Service Act gives general powers to Local Health Authorities 'to provide domestic help for households where such help is required owing to the presence of any person who is ill, lying-in, an expectant mother, aged, or a child not over compulsory school age within the meaning of the Education Act, 1944',[2] and all such authorities have now approved schemes. Contrary to expectation the recruitment of staff has not proved unduly difficult, and the Ministry suggests that it is the cost of the service, rather than any difficulty in obtaining helpers, which is limiting its further development at the present time.[3] It has proved particularly valuable to the chronic sick and infirm, enabling some who otherwise would have been forced to enter hospital to remain in their own homes or with relatives. Like the loan service, this service is one of the few services provided under the Act for which a charge, appropriate to the means of the user, can be made.

[1] Op. cit., Section 28. [2] National Health Service Act, Section 29.
[3] Report of the Ministry of Health for the year ended 3rd March 1949, p. 122.

The therapeutic value of a period of convalescence especially for those for whom return home after a spell in hospital means return to poverty, anxiety, overcrowding and overwork, has long been recognised, and convalescent homes have been established in all parts of the country by voluntary organisations, hospitals savings schemes, trade unions, friendly societies and other associations. They vary widely in character, some being holiday homes or recuperation centres, catering for people 'run down' and needing restful holidays with fresh air and good food, as well as those recovering from illness or operation, while others provide more in the way of medical supervision and nursing care. There is no hard and fast line between the two types, however, and since the passing of the National Health Service Act this has led to some administrative confusion, since those convalescent homes which are regarded as providing 'treatment' have been transferred to the Minister, and are considered as part of the hospital service of their respective regions, while the others remain outside, and continue to operate on their former basis. Moreover, local authorities may include convalescent care among the services provided under Section 28 of the Act, and the extent to which they do this, either by using homes of their own, or paying for patients sent to voluntary homes, varies from authority to authority. In either case, the patient may be asked to contribute to the cost of his care, and is at a disadvantage compared with the one sent to a home transferred to a Regional Hospital Board. In view of the difficulties to which this situation has given rise the Minister has asked Regional Hospital Boards to undertake surveys of the untransferred homes in their regions, placing them in three categories according to the extent to which 'treatment' as distinct from 'recuperative care' is given in order that convalescent homes may be allocated to their appropriate place in the scheme and proper use made of resources.[1] As before the passing of the Act, voluntary associations, friendly societies and the like continue to play an active and valuable part in the provision of this form of care.

Among the most important responsibilities of the Local Health Authorities are those in connection with the prevention of tuberculosis and the care and after-care of persons suffering from this disease. The serious nature and social implications of this complaint, with its high death and disability roll, especially among young adults and those in the prime of life, its infectious character, and its close association with such evils as poverty, overcrowding, bad housing and unhealthy working conditions, have long been recognised. The need for a comprehensive tuberculosis service, which would include provisions directed towards both the pre-

[1] Ministry of Health Circulars R.H.B. (49) 33 and (49) 49.

vention and the treatment of the disease, was brought to the notice of the public by the issue, just before the First World War, of the Interim and Final Reports of the Departmental Committee on Tuberculosis[1] which recommended that County Councils and County Borough Councils should draw up plans for preventive and treatment services in their areas. The Interim Report suggested that these provisions should include 'dispensaries', that is local centres of expert diagnosis and treatment, which should be clearing houses through which all cases of tuberculosis should pass, at which the examination of contacts should take place, and from which after-care and educational work should be carried out. The necessity for adequate sanatorium and hospital accommodation to provide institutional care for those who needed it was also emphasised. During the years immediately following the publication of these reports local authorities began putting their recommendations into practice, and the Tuberculosis Act, 1921, consolidated this advance by making provisions for the diagnosis and treatment of tuberculosis along the lines suggested by the Departmental Committee a statutory duty of all County Councils and County Borough Councils. From then until the implementation of the National Health Service Act, unified schemes were in operation in each major local authority area, and, although there were variations in standard, the service gradually became more effective. Between 1921 and 1948 deaths from tuberculosis decreased at an average annual rate of 2·9 per cent.[2]

The National Health Service Act has made radical changes in the administration of the tuberculosis service. Hospitals and sanatoria have been taken over by the Regional Hospital Boards and with them go the tuberculosis dispensaries, now transformed into, or replaced by, 'chest clinics'. The Local Health Authorities retain their responsibilities for the control of tuberculosis by such means as the supervision of notifications, health education, the examination of contacts and provision of alternative care for their children in co-operation with the local authority's Children's Department, should this be necessary. They are also responsible for the social care of patients awaiting places in sanatoria, and for their after-care on return from treatment. Such after-care, which may be carried out directly or through a voluntary Tuberculosis Care Committee, where such exists, is designed 'to help solve the special

[1] The Committee was set up in February 1912; the Interim Report was published later in the same year, the Final Report in 1913.

[2] Report of the Ministry of Health for the year ended 31st March 1949, Cmd. 7910, p. 107. In the six years before 1938 mortality from respiratory tuberculosis declined by 24 per cent for males and 28 per cent for females; in the 10 years following (which included the war years) the fall was 13 per cent for males and 15 per cent for females. Ibid., p. 23.

problems of the tuberculous household and so to facilitate treatment by relieving anxiety; to safeguard the restored patient against relapse and to preserve the health of the family which is exposed to special risk'.[1] Special measures, such as the provision of workshops, hostels, night sanatoria and village settlements may be desirable in some areas, and had already been provided by certain local authorities before the implementation of the National Health Service Act. They are now among the 'care and after-care' services covered by Section 28 of the Act.[2]

The chief advantage of the new administrative arrangements for the control and treatment of tuberculosis would appear to be the possibility of a closer link between the tuberculosis service and the general hospital service, and its extension to cover all diseases of the chest.[3] On the other hand the new set-up has been criticised on the grounds that it replaces a unified service, embracing prevention, treatment and after-care, by one in which responsibility for prevention and community care has been separated from that for institutional treatment. At least one critic would go further, for Dr. Fraser Brockington, formerly County Medical Officer, West Riding County Council, wrote in a recent annual report: 'Separation of responsibility in itself does no grave harm, for two parts can work together as one whole, given the will, the disadvantage and danger comes from the shift of emphasis from prevention to cure. Is it not significant that the "tuberculosis officer" is now a chest physician? That is the epitome of what has happened, a disease which embraces the whole life of the community . . . is now a matter of the chest.'[4] This is a drastic criticism, which may not be generally accepted, but it draws attention to the necessity for all concerned to take a broad view of the problem, and to see their particular contribution to its solution as part of a concerted effort. It is only by the mobilisation of the resources of scientific research, clinical treatment, health and social care that this particular enemy of mankind can be overcome.

The controversies at the inception of the National Health Service are now remote; it is rapidly becoming a national institution to be taken for granted, just as a state system of education and old age

[1] Ministry of Health Circular 118/47, par. 42, p. 13. See also Norman Macdonald, 'The Social Aspects of Tuberculosis', *The Almoner*, Vol. II, No. 7, October 1949, pp. 148 ff. for a discussion of the types of after-care needed for different types of patient and the difficulties and possibilities of providing them.

[2] Ministry of Health, ibid., par. 38.

[3] British Medical Association, *Tuberculosis and the National Health Service.* Report of the Tuberculosis and Diseases of the Chest Group Committee, approved by the Council of the Association, November 1950, pars. 4 and 5.

[4] County Council of the West Riding of Yorkshire, Sixty-first Annual Report of the County Medical Officer, 1949, p. 28.

pensions are taken for granted. It has freed numerous families from serious anxiety about their ability to afford medical treatment should it be required, and, while in the early years there was some 'patient abuse', many persons long in need of medical care, but hitherto prevented from seeking it as they were not entitled to medical benefit under National Health Insurance Acts, are now obtaining the treatment they require. Even the much publicised rush for teeth and glasses included numbers of men and women who for long had been putting up with the discomfort of decayed teeth, or 'making do' with glasses purchased at a chain store, while the Ministry of Health attributes the marked increase in the waiting lists for gynaecological beds noted by the hospitals during the first nine months of the service, to the revelation of 'previously unsuspected conditions in those persons who formerly were not covered by National Health Insurance, and now more readily consult their family doctors'.[1] The long-term effects of earlier and more widespread consultation and where necessary treatment on the health of individual and the nation as a whole cannot yet be assessed, but eventually it should mean economic as well as social gain, as it should increase working efficiency and reduce the time lost through sickness.

Widespread concern has been caused by the high overall cost of the National Health Service. This has risen steadily since the implementation of the Act, and now far exceeds the original estimates.[2] Moreover, there has been a considerable amount of adverse criticism of the way in which the money allocated to the Service has been distributed between its different branches, the early very heavy expenditure on the ophthalmic and dental services coming in for particularly heavy criticism. Thus a writer in *The Practitioner* review of the first year's working of the service draws attention to the fact that, according to the estimates for 1949–50, the cost of the dental and ophthalmic services taken together amount to more than the whole cost of family doctoring, and comments: 'Something has gone wrong with priorities within the health service itself when it is possible to estimate the worth of the services of the general practitioner twenty-four hours a day, the whole year round, no higher than the cost of providing dental treatment and spectacles.' In the case of the dental service point was added to the criticism when the disastrous effects of high earnings in National Health Service dentistry on the school dental service were considered.

[1] Ministry of Health, Annual Report for the year 1948–9, p. 120, cf. Chapter IV, p. 57, above.

[2] The total cost of the services provided under the National Health Service Act was about £486,000,000 for England and Wales in the financial year ended 31st March 1953. The present and prospective cost of the health service is being reviewed by a committee with Mr. C. W. Guillebaud as chairman.

As we have already seen legislation designed to limit public expenditure on dentures, spectacles, drugs and medical appliances by imposing charges on these items has now been passed and seems to be having some effect. These charges do not apply to hospital in-patients, patients in receipt of National Assistance or to war pensioners in respect of their accepted war disability. Other persons who are unable to afford the charges may apply to the National Assistance Board for a grant towards them, and in these cases the Board is empowered to waive its general rule of not assisting persons in full-time employment. Hence it appears that while a serious modification of the original conception of a comprehensive service free to the user has been brought about, a genuine attempt has been made to make the economies considered necessary in the national interest in such a way as to impose as little hardship as possible.

Dentures, spectacles and appliances were obvious targets for criticism at first but of more long-term importance is the general question as to whether there may not be a tendency in the administration of the service to meet immediate needs, and satisfy the public demand for tangible benefits, at the expense of provisions which, in the long run, will contribute more to the health and well-being of the people. At the present time the aspects of the service most in the public eye are those concerned with treatment, and the service as a whole is being judged by the extent to which it fulfils its promise of providing medical care, by the quality of the care given, and by the efficiency and economy of the administrative arrangements for providing it. In the long run, however, it will also be judged by the extent to which it has contributed to the 'improvement of the physical and mental health of the people'. Such an improvement is largely dependent on factors outside the scope of the National Health Service, for example, better housing conditions, the abolition of acute poverty, and the reduction of nervous strain. It will also be influenced, however, by the extent to which the possibilities contained in the Act for developing preventive health work are exploited, and research into social medicine, and experiments in the field of health education, in particular, education in the meaning of positive health, are encouraged.[1] These developments are as important as the new developments in clinical surgery and medicine, and both should be fostered, since both are needed if the inhabitants of this country are to achieve 'perfect soundness' of mind and body, and become healthy citizens in a healthy society.

[1] See T. Ferguson and A. N. MacPhail, *Hospital and Community*, 1954 (a study made in four Scottish hospitals which demonstrates that the effects of hospital treatment may be nullified on the patient's return to bad living and working conditions).

CHAPTER VI

SOCIAL ASPECTS OF HOUSING AND TOWN PLANNING

'Town planning is not mere place-planning, nor even work-planning. If it is to be successful it must be folk planning.

'This means that its task is not to coerce people into new places against their associations, wishes and interest. . . . Instead its task is to find the right places for each sort of people. To give people in fact the same care as we give when transplanting flowers. . . .'—*Patrick Geddes in India.*

THE seriousness of the present shortage of housing accommodation and its social consequences are too well known to need stressing here. Overcrowding, bad housing conditions, and the inability to find a home of one's own, make the creation of stable family life difficult for many people, and may give rise to great personal unhappiness and serious physical and mental strain. The double task of overcoming this shortage and raising housing standards is by no means an easy one. Some of the difficulties to be overcome, such as the shortage of timber and other building materials, and the organisation of the building industry, are technical and economic. These questions are important, and indeed crucial, but are outside the scope of this study, where attention is focused on social problems and policy, and it is the social aspects of housing with which we shall be dealing.

British housing policy aims at providing a sufficient number of fit houses for the families of the nation. It rests on the assumption that each family, by which is meant each married couple with their immature children and unmarried sons and daughters who wish to live at home, is entitled to a home of its own, and should not be compelled to share this with elderly parents or other relations because these are unable to find separate accommodation elsewhere. It may be, as Margaret Mead has suggested,[1] that the modern assumption that each generation, as it reaches maturity, should lead its own life in its own home, with as few responsibilities as possible for relatives other than dependent children, has, in the long run, certain adverse effects on family stability and happiness, but since this loosening of kinship ties is now widely accepted,

[1] *Male and Female*, 1950, ch. xvi, 'Each Family in a Home of its Own'.

allowance must be made for it in assessing housing needs. It means that provision must be made for smaller but more numerous households,[1] and special accommodation arranged for aged and single persons.[2] The number of families who now live as parts of bigger units, but who would split up into separate households if sufficient dwellings were available, is not known, and is difficult to assess, since there are probably many persons who are vaguely discontented with their present situation, but who if given the chance of setting up a separate household would find it difficult for personal and economic reasons. It is possible, however, that the numbers of 'potential' or 'concealed' households is considerable, and their existence a serious complicating factor in the life of many families.

One of the most serious aspects of the present housing situation is the overcrowding which it entails. This overcrowding may be due either to disparity between the size of the family and that of the dwelling they inhabit, or to sub-letting or the sharing of houses. A nation-wide survey of its extent and distribution was made in the spring of 1936.[3] This has not been repeated since the war. The 1951 Census reports contain information about overcrowding and sharing dwellings. The standard used in the 1936 survey was laid down in the Housing Act, 1935, and it is still the 'official' or 'statutory' overcrowding standard. By this standard a dwelling is overcrowded if there is no provision for separate sleeping accommodation for the sexes after they reach the age of ten; if the number of persons living in it exceeds the number 'permitted' for the number of rooms available, and if these rooms are less than a certain specified size.[4]

This official standard has been subject to a good deal of criticism chiefly on the grounds that it fails to differentiate between bedrooms and living-rooms. It can be demonstrated that the use

[1] The term 'household' is used here to mean a group of people, who may or may not be related to one another by blood, living together as a housekeeping unit, and sharing meals, e.g., two friends living together would constitute a household, as would a person living alone.

[2] This is discussed in greater detail in *Planning*, Vol. XV, No. 293, 10th January 1949—'The Assessment of Housing Needs'.

[3] Ministry of Health, *Report of the Overcrowding Survey of England and Wales*, 1936. About 4 per cent of the dwellings surveyed were found to be overcrowded on the standard laid down in the Housing Act, 1935.

[4] Where a house consists of 1 room the permitted number of occupants is 2 persons, 2 rooms 3 persons; 3 rooms 5 persons; 4 rooms 7½ persons; 5 rooms 10 persons, with the addition of 2 persons for each room in excess of 5. Children under the age of 1 year are not counted, and children between the ages of 1 year and 10 years count as half. The permitted number of occupants is reduced when a room has a floor area of less than 110 sq. ft., and bathrooms, sculleries, etc., are not counted.

of the living-room for sleeping purposes without detriment to health is perfectly feasible, but this is incompatible with the accepted standards and modes of life of the majority of the people.[1] Hence, after taking into account the views of several witnesses, the Housing Management Sub-committee of the Central Housing Advisory Committee has recommended that a better measure of overcrowding for the purpose of assessing housing need would be a measure of bedroom deficiency, that is, one based on the number of bedrooms over and above those already occupied that a family would need for adequate sleeping accommodation.[2] The difference this would make is indicated by a survey of housing in Birmingham made in 1946, which revealed that if living-rooms were excluded for sleeping purposes, 11·26 per cent of the households surveyed would be overcrowded compared with the 1·92 per cent overcrowded on the statutory standard.[3]

In order to obtain a realistic picture of the housing conditions in an area and form a better estimate of housing needs, it is necessary to try and assess not only the numbers of dwellings which are overcrowded, but also the numbers in which the accommodation exceeds the requirements of the occupants, and the extent to which interchange is possible. There appears to be a considerable amount of maldistribution of houses. For example, the social survey of Middlesbrough which was made in September 1945 included an analysis of the number of habitable rooms occupied by families of different size, and revealed that 37 per cent of the families in the sample who occupied houses of six or more rooms were families of one or two persons, while only 38 per cent of the total number of families surveyed consisted of this number. On the other hand, only 16 per cent of the families occupying six or more rooms were families of five or more persons, while 19 per cent of the total number of families in the sample were families of this size.[4] A more recent investigation into overcrowding and under-occupation in Dudley confirms this evidence of maldistribution, since it revealed that, if the rather arbitrary standard of one person per room were

[1] The Social Survey of Middlesbrough carried out by Dennis Chapman on behalf of Wartime Social Survey included a calculation of the average number of bedrooms per family, and the average number of rooms used for sleeping by the family, for households of different sizes. It showed that although the number of rooms per head decreased with the size of family there was very little evidence that this was compensated for by using other rooms in the house for sleeping. Op. cit., pp. 17 and 18.

[2] *Selection of Tenants, Transfers and Exchanges*, Third Report of the Housing Management Sub-committee of the Central Housing Advisory Committee, H.M.S.O., 1949, p. 7.

[3] City of Birmingham, Report of the Medical Officer of Health, 1946, p. 73.

[4] Wartime Social Survey, *A Social Survey of Middlesbrough*, by Dennis Chapman, Part I, p. 17.

taken as the standard of overcrowding, then 46·6 per cent of the households in the population had housing accommodation in excess of their needs, 23·0 per cent were on the margin and 30·1 per cent were overcrowded.

The possibility of making adjustments between under-occupied and overcrowded houses would appear to be much more limited than the figures given in the above paragraph would suggest, however. Questions of location, rent, ownership and the status and wishes of the occupier have all to be taken into account. The business man and his wife occupying their own suburban villa of six or seven rooms may balance the family of six or seven persons overcrowded in a two-up and two-down house in the slums in a statistical table, but an exchange between the two is hardly within the bounds of possibility. Such exchanges are, however, more possible between the tenants of corporation houses, and in 1945 the Housing Management Committee of the Central Housing Advisory Committee endeavoured to find out by means of a questionnaire the extent of overcrowding and under-occupation in houses owned by local authorities.[1] They also sought the opinion of expert bodies, such as the Society of Women Housing Managers, the Institute of Housing and the Sanitary Inspectors Association, as to the causes of maldistribution and how best it might be overcome. As a result of this investigation they concluded that the available evidence did not suggest any general prevalence of under-occupation of houses owned by local authorities. Where it existed in conjunction with overcrowding it might be relieved to some extent by exchange of tenancies, which should be encouraged as much as possible. Its possibilities are limited, however, until a wider variety of housing accommodation is available. In particular, the provision of a larger number of small units for elderly persons would relieve the pressure on family houses, while the needs of the larger family, requiring more than the standard three bedrooms, can only be met by building larger numbers of this type of house.

One of the obstacles in the way of overcoming the overcrowding due to the occupation of small houses by large families is the relatively high rent charged for houses of adequate size. In spite of family allowances and other welfare provisions, a family which includes a number of dependent children is economically at a disadvantage compared with a smaller family in the same social

[1] Thirty-one local authorities comprising 6 County Borough Councils, 14 Borough and Urban District Councils and 11 Rural District Councils were asked for statistics as to the number of spare bedrooms in houses on their estates. Figures relating to 45,884 houses were received. Of these 88 per cent were without a spare bedroom, 9 per cent had one spare bedroom and 3 per cent two spare bedrooms. *Housing Management*, 1945 (Reprinted 1949), p. 10, also Appendix II, pp. 20–1.

class,[1] yet, if it is to obtain the accommodation it requires, it must normally pay a higher rent for it, and unless the local authority operates a rent rebate scheme, this applies to local authority as well as privately owned houses. This raises what is perhaps the most difficult general problem of housing policy, that of providing houses which will meet the needs of families in the lower income groups at rents which these families can afford to pay, and do this without laying an unjust financial burden on these families who, although their living conditions are far from ideal, cannot hope to obtain a municipal house within a measurable time.

The first attempt to deal with this problem on a national basis was made immediately after the end of the First World War. At that time the housing situation was similar in many respects to that at the end of the recent war. There was a serious overall shortage of accommodation, but the greatest need was for houses to let at rents which working people could afford to pay. Building costs had risen, however, and it was impossible to build houses of what was regarded as an adequate standard except at a capital cost which would entail a high economic rent.[2] To meet the situation the Government, using money obtained by taxation, granted subsidies to local authorities, and, to a lesser extent, to private builders who were prepared to build houses which reached the required standard to let to working-class people.[3] The policy of subsidising the provision of working-class houses has continued in one form or another ever since, although after 1933 subsidies were discontinued except for accommodation provided to rehouse families cleared from slums. By this time, the general housing shortage had abated somewhat, although the demand for houses to rent had never been wholly met, and there were many people living in substandard dwellings in which there was a minimum of comfort and amenity, but which were not sufficiently detrimental to health to be scheduled for slum clearance.

At the end of the Second World War the shortage of housing accommodation was once again acute and widespread among all classes. Consequently the Government laid it down as a matter of

[1] See A. M. Henderson, 'The Cost of a Family', *Review of Economic Studies*, Vol. XVII (2), No. 343, 1949–50, p. 127.

[2] The 'economic rent' of a house is the rent which must be charged if the cost of building and other charges are to be recovered within a reasonable period.

[3] For example, in order to qualify for a subsidy under the Housing Acts of 1923 and 1924 as consolidated by the Housing Act, 1925, houses were required to contain a bath in a bathroom; the density per acre must not exceed 8 houses in agricultural districts and 12 elsewhere; the floor area had to be between 620 and 950 superficial feet in the case of cottages, and 550 and 880 superficial feet in the case of bungalows or flats.

policy that the proportion of the nation's resources, materials and man-power, which was available for building new houses, must be used to build houses for those in greatest need of accommodation whatever their social class. The declared object of this policy was to meet the housing needs of all members of the community, and in the Housing Act, 1949, all those provisions in previous Acts which limited the powers and responsibilities of the local authorities to providing accommodation for the 'working classes' were deleted.[1]

As in the years immediately following the First World War, one of the major difficulties of implementing a policy of providing a sufficient number of houses at moderate rents has been that of building costs, which have risen very considerably since 1939,[2] and in 1946 a new general subsidy of £22 a house (£16 10s. from national funds, and the remainder payable by the local authority building the house) was authorised.[3] It was hoped that this would keep the rents of post-war houses on a level with those built before the war, but the continued rise in costs has prevented this. The subsidy enabled local authorities to reduce the rents of houses built with its aid by 8s. 6d. a week, but even so they are still very high. Thus a survey of rents of three-bedroom non-parlour houses carried out by P.E.P. in 1949, and covering 162 local authorities in England and Wales, showed that the average gross rent[4] for pre-war houses was 15s. a week, compared with about 11s. in 1939, while the national average of gross rents for post-war houses was 21s. This average is rather deceptive, however, as the variations are wide. Nearly half the weekly rents charged are 20s. or less, but one-sixth (mainly in the south) are over 25s. On the basis of the data they collected P.E.P. calculated, that an income of at least £6 a week was required for the tenancy of the three-bedroom post-war houses provided by half the authorities included in the survey, if one-sixth of the weekly income were regarded as a reasonable proportion for a family of two or three children to set aside for rent. Thus, in spite of the subsidy, families in the lower income groups, however urgent their need for better accommodation, cannot move into the houses now being built unless they are prepared to make considerable sacrifices in other directions

[1] Housing Act, 1949, Section 1.

[2] In 1947 the average cost of building a local authority house was £1,242, compared with £380 in 1939.

[3] In 1952 the standard Exchequer subsidy was raised to £26 14s., the rates contribution being £8 18s. It has since been reduced to £22 1s. with a rates contribution of £7 7s. for houses built after 31st March 1955.

[4] I.e., Rent including rates. Rates had gone up in 95 per cent of the authorities' areas.

which might be so serious as to counteract the advantages of the move.[1]

It would appear then that the present subsidies are ineffective as a means of bringing reasonably good housing accommodation within the reach of the lower-paid worker, and many of the tenants of the new houses are people and families who are quite well off. If the Government's policy of 'mixed development'[2] be accepted, the inclusion of better-class families on housing estates may be an advantage in some respects, but the justice of subsidising them from rates and taxes may be questioned, since this creates 'a privileged class who are receiving a contribution towards their expenses from people poorer than themselves and living in dwellings of a far lower standard'. 'It is illogical that a family should be unable to afford the rent of a new house, when the rates included in the rent are levied partly to subsidise a neighbour who could do without this assistance.'[3]

The anomaly just described is due in large measure to the fact that subsidies are paid at standard rates, and bear no specific relation to the means of tenants who may be occupying the subsidised houses. A possible means of dealing with the situation would be the wider adoption by local authorities of rent rebate schemes. Such schemes vary in detail,[4] but they all involve reducing the rent to a level which it is considered the family can afford. This may be calculated either by fixing a minimum subsistence income which should be left after the rent has been paid, or by limiting the

[1] The study made by Dr. McGonigle when M.O.H. of Stockton-on-Tees into the mortality rates of two groups of people who until 1927 were living in insanitary conditions in this town, is suggestive in this connection, although the evidence is not conclusive, and the figures have been questioned. In this year half the population of the area was rehoused on a new well-built housing estate, the other half remained in their insanitary homes. Contrary to expectation the death-rates, both crude and standardized, of the proportion which had been moved compared unfavourably with those of the familes which remained. After considering possible explanations for this Dr. McGonigle came to the conclusion that the families on the estate were suffering from dietary deficiencies caused by trying to make their low incomes (many were unemployed) cover the higher rents of the new homes. G. C. McGonigle and J. Kirby, *Poverty and Public Health*, 1937, ch. vii. Cf. *Population Problems of New Housing Estates*, p. 20, where the M.O.H. of Huyton and Roby is quoted as saying that the tenants of the housing estate there were receiving fresh air at the expense of their food.

[2] This is discussed on p. 96.

[3] *Planning*, Vol. XVI, No. 212, 24th April 1950—'A New Policy for Housing Subsidies', p. 264.

[4] A review of the present position with regard to rent rebates with examples of schemes used by selected local authorities was published by the Society of Housing Managers in April 1950. Examples of means used by other countries to adjust rents according to income are given in *Planning*, Vol. XVI. No. 312, April 1950—'A New Policy for Housing Subsidies'.

rent payable to a certain proportion, usually one-fifth or one-sixth, of the family income. The money to finance such a scheme may be found by an additional contribution from the rates—a measure which has the disadvantage of imposing a further burden on those who are not enjoying and can never hope to enjoy the benefits of a subsidised dwelling—or by using the whole or part of the statutory subsidy for the purpose.

Although local authorities have possessed powers to grant rent rebates for a number of years, comparatively little use has been made of them. Thus only 78 of the 941 housing authorities who replied to a circular issued by the Society of Housing Managers to the 1,470 authorities in the country, admitted to having a rebate scheme, although an additional 72 said that rebates were given in cases of special hardship in spite of the fact that there was no general scheme, and a further six that schemes were under consideration. Against these must be set the 55 authorities who at one time had schemes and have since abandoned them. The objections made to rent rebate schemes by authorities who were not using them included objections on principle, such as the one that they provide for reduction of rent for municipal tenants in times of financial difficulty, and this is unfair to tenants of other houses who do not share the privilege; dislike of administering a means test; fear that dissatisfaction might be caused by charging differing rents for similar accommodation, and the general difficulty and expense of administering such a scheme.[1] These objections carry considerable weight, but if housing costs remain high, as they appear likely to do, then unless some means are found of adjusting rents so as to bring them within the means of poorer families, the declared objective of housing policy, that of providing good housing accommodation for those whose housing needs are greatest, cannot be fulfilled.

The suggestion has sometimes been made that the present high cost of building houses could be reduced, and more houses built in a given time, if the standards of house building were reduced. Between 1939 and 1947 the cost of building an average three-bedroom council house rose from £380 to £1,323, and while much of this increase could be attributed to increased wages and prices, it was in part due to an increase in size from an average of 800 square feet to an average of between 950 and 1,050 square feet, excluding outhouses,[2] and in part to an improvement in amenities. While these improvements are desirable, it can be argued that the present shortage is so acute, and present costs so high, that the possibilities

[1] Society of Housing Managers, op. cit., pp. 25 and 26.

[2] P.E.P., *Planning*, Vol. XVI, No. 308, 23rd January 1950—'Economics of the Council House', p. 90.

of building simpler and cheaper houses should be carefully considered. The policy of the Labour Government in this matter was set out in a circular issued in April 1951[1] which permitted local authorities to make overall reductions in the size of house built, provided that the standards laid down in the Housing Manuals for the size of individual rooms and total living space were maintained. This policy has been continued by the Conservative Ministers of Housing and Local Government, who have been encouraging local authorities to build houses according to designs prepared by the Ministry, which conform to existing standards of room size and living space, but which are of smaller superficial area.[2]

In addition to conforming with these standards of size houses must accord with 'modern requirements of comfort and amenity'. This means that they must be soundly constructed and properly designed and equipped for family living. Of recent years a number of investigations have been made into the design and equipment of dwellings[3] and this type of research is having good results.

An important question which must be considered in connection with the design of dwellings is whether, and under what conditions, a full and happy family life is possible in a block of flats.[4] This is a major issue for the housing authorities of large cities, who are faced with the alternative of moving families out to remote suburbs or satellite towns, or housing them in multi-storied flats in the inner districts. The advantages of flats near the centre of the town are that the time-distance and expense of the journey to work are reduced; shopping centres, places of entertainment and other amenities are more accessible; the town is kept more compact and hence land is preserved for agriculture; and the family remains in the neighbourhood which however drab it is, is the neighbourhood to which it feels it belongs.[5] On the other hand, life in a block of

[1] Ministry of Local Government and Planning, Circular No. 38/51, *Housing Standards*.

[2] Parliamentary Debates, House of Commons Official Report, Vol. 494, No. 19, 27th November 1951. Col. 1102.

[3] See Ministry of Health, *Design of Dwellings*, 1944; *The Lighting of Buildings*, 1944; *A Survey of Noise in British Homes*, 1949.

[4] *Living in Flats*, a report of the Flats Sub-committee of the Central Housing Advisory Committee discusses the social needs and problems of families living in large blocks of flats in a practical and constructive manner. H.M.S.O. 1952.

[5] E.g., the Report of the Manchester University Settlement Survey of the Ancoats Clearance Area records that 'the intensive visiting on the survey has confirmed the impression held by most settlement workers that Ancoats is a community. 41·2 per cent of the 460 families visited had been in the same house for over 20 years, and of the 460 families with a tenancy of less than 5 years, 117 were Ancoats families in the sense that one or both parents had been born or brought up in the district.'

flats near the centre of a large town has considerable disadvantages, especially for families with young children, for 'However desirable or indeed inevitable blocks of flats may appear to the town planner, they deny to children certain vital needs', of which space in which to play and contact with living and growing things are among the most important.[1] These needs may be met in part by the provision of communal gardens and well-equipped play spaces and nurseries such as those which are often found in connection with the Scandinavian flats, and help to make them so attractive, but even these amenities do not wholly compensate for space indoors where a child can make a noise without unduly disturbing the neighbours, for the possibility of keeping pets or for the possession of a garden into which the toddler can run at will without climbing down several flights of stairs. Hence, as far as possible, families with children should be accommodated in houses with their own gardens, however small, and flats built mainly to accommodate the single and childless. There are, however, certain areas, such as the dockland areas of London and Liverpool, where the families must be housed within easy reach of the wage-earner's work. In these areas multi-storied blocks of flats would seem to be the only means of providing the necessary accommodation and they should be made as attractive in appearance and provided with as many amenities as possible.[2]

So far, in this chapter, we have been concerned with the means of providing suitable housing accommodation for the families of the nation who are in need of it, but provision in itself is insufficient, and the best efforts of an inspired city architect or planner may be frustrated, and conditions on an estate or in a block of flats quickly deteriorate, if they are not accompanied by good management. On the other hand, good management may lead to improvements in standards even where conditions are not very satisfactory. Its importance and possibilities were first realised and demonstrated in practice by Miss Octavia Hill, disciple and friend of Ruskin, who in 1864 undertook the management of three tenement houses in London where conditions were extremely bad. In time she 'not only converted these dwellings into clean, sanitary

[1] L. E. White, *Tenement Town*. Cf. J. B. Mays, *Growing Up in the City*, 1954 (particularly Chapter 3).

[2] The Dudley Committee suggests that these might include lifts; chutes or a waterborne system of refuse disposal; pram and bicycle sheds on the ground floor; communal laundry facilities; crèches or playrooms for children and a community hall. See Ministry of Health, *Design of Dwellings*, 1944, Section VI. See also Memorandum submitted to the sub-committee of the Central Housing Committee on 'The Social Needs and Problems of Families living in Large Blocks of Flats', *Quarterly Bulletin of the Society of Housing Managers*, Vol. III, No. 2, April 1951, pp. 9–12.

homes and brought order into the lives of the tenants, but she also made the venture pay'.[1] This demonstration of the possibility of combining good social work with good business soon attracted attention. More and more property was given into her charge, she began to train other women in her methods, and her ideas spread, not only in this country, but to other parts of the world also, so that housing management is now recognised as an important and integral part of housing policy.

Housing management as understood by the Society of Housing Managers, which continues the work begun by Octavia Hill, is based on three principles. The first of these is that landlord and tenant have a mutual responsibility towards the property and should work together to preserve and enhance its value and usefulness; the second that the business and social welfare aspects of housing management are not independent spheres of activity, but should be combined, while the third is that good relationships must be maintained between the landlord or his representative and the tenant. The first of these principles is generally accepted but there are differences of opinion about the second. Some local authorities prefer to keep the business management of their estates, including the collection of rents and oversight of repairs, distinct from the welfare work which is undertaken to help the tenants adjust themselves to their new environment and raise their standards of housing care. The chief arguments in favour of the Octavia Hill system of combining the functions of rent collector and social worker, are that the collection of rents and oversight of repairs provides a right of entry into every house for a known and accepted business purpose, and there is no obvious singling out of 'undesirable' or 'problem' families for special visiting. Further, as the worker visits weekly, she gets to know the family when times are normal, as well as when trouble or difficulty occurs. On the other hand, it means that a trained and skilled social worker may have to spend the greater part of her time doing routine work, and even by limiting her visits so that there is little time for real social work, she cannot undertake to visit more than about 100 tenancies a day or 400 or 500 a week. Hence, many times the present number of trained workers would be needed if local authorities owning several thousand houses adopted this system of management.

Whether the exact method adopted is that advocated by the Society of Housing Managers, or the alternative of appointing separate welfare workers, it is important that someone should be available whom the tenants know and trust, and to whom they can

[1] Society of Women Housing Managers Inc., *Housing Estate Management*, 1946, p. 2. For a life of this remarkable woman see E. Moberley Bell, *Life of Octavia Hill.*

turn in times of difficulty. Such a person should get to know the family before they leave their old home, help them through the removal, and keep in close touch with them during the first difficult weeks while readjustments are being made and the family is finding its place in the new community. She would thus become a symbol of friendship and understanding in a system of management which would otherwise appear to be impersonal and remote, and, as such, she might make all the difference to the tenants' attitude towards the authority.

While Octavia Hill housing management or some system of welfare visiting provides the personal element so essential to good management, it is still authoritarian management from without. Of late there have been some indications that, just as there is a growing demand for democracy in industry, so there is a demand that more should be done to encourage the tenants to play a greater part in the management of their own estates by means of tenants' associations or similar organisations. Thus, a writer in the *Quarterly Bulletin of the Society of Housing Managers* for January 1950, contends that 'The methods evolved by Miss Hill to help and protect people too poor and ignorant to help themselves are becoming anachronistic to-day' and suggests that with the elimination of gross poverty among council tenants, and the inclusion among them of people with higher standards of education, and often occupying positions of considerable responsibility, there is both a need and an opportunity for encouraging tenants to co-operate in managing the estates on which they live.[1] The extent to which this is possible and the methods by which it can be brought about will vary according to the size and character of the estate, but it would appear that the devolution of responsibility for such matters as affect the common good as the control of wireless, the keeping of pets and the care of gardens, would encourage the tenants to acquire a sense of responsibility for, and pride in, the estate, and would foster active democracy and the development of community life. At the same time many families will still have difficulties that they would probably prefer to confide to a disinterested yet sympathetic official than to a council of neighbours, and although housing estates are being tenanted in the main by families with good standards, there are still some who need a great deal of skilled social care and teaching before they can benefit from their new opportunities and environment. Hence, while the scope and character of the housing manager's or welfare worker's

[1] M. I. Sharp, 'Management To-day: The Part of Tenants' Associations', *Quarterly Bulletin of the Society of Housing Managers*, Vol. II, January 1949, p. 6. See also a criticism of this article 'Are Octavia Hill's Methods Obsolete?' by E. Moberley Bell in the July issue of the same bulletin.

work may change, she should continue to play an important part in housing management.[1]

One of the most difficult problems of housing management is the selection of tenants. In view of the acute shortage of houses and the personal unhappiness and social evils which can be attributed, either directly or indirectly, to overcrowding and unsatisfactory housing conditions, it is understandable that the only basis for the allocation of the available housing accommodation which is generally acceptable at the present time is that of 'housing need', measured by such criteria as the size and health of the family, the degree of overcrowding and the state of the existing accommodation. While this is generally recognised by local authorities in planning schemes by which priorities can be determined, some authorities give considerable weight to less relevant factors such as war service, length of residence in the area and length of time on the waiting list. The Housing Management Sub-committee of the Central Housing Advisory Committee suggests that such factors should only be taken into account in order to distinguish between cases whose housing need is equal,[2] and this would seem to be the fairest procedure.

While a clearly defined 'points' or priority scheme, the principles of which are known and understood by the families applying for houses, is essential as the basis for the selection of tenants, 'the varying needs of many thousands of individuals cannot be finally reduced to a mathematical formula'.[3] Hence, final selection should only be made after careful investigation of the applicant's circumstances, which should, if possible, include the visiting of the family by a competent official, preferably a trained housing manager or social worker, who would then keep in touch with the family throughout the waiting period, help them through the removal and settle them in their new home.

Under existing circumstances housing need is likely to remain the main criterion for the allocation of municipal houses both pre-war and post-war for some time to come, but unless precautions are taken this may have an adverse effect on the composition of the population of local authority housing estates, and prejudice

[1] Some of the issues outlined in the above paragraph are discussed in more detail in *Planning*, Vol. XIV, No. 282, 21st May 1948—'Councils and their Tenants'.

[2] Ministry of Health, *Selection of Tenants and Transfers and Exchanges*. Third Report of the Housing Management Sub-committee of the Central Advisory Committee, H.M.S.O., 1949, p. 10.

[3] Memorandum submitted by the Society of Women Housing Managers to the Housing Management Sub-committee of the Central Housing Advisory Committee, and quoted in the Second Report of this Committee, *Management of Municipal Housing Estates*, pp. 7 and 19.

their chances of developing into healthy and well-balanced communities. One danger to be guarded against is that of overweighting a particular area with families with young children, since these form the majority of the families in great need of better accommodation. This was one of the mistakes made by many housing authorities in the years after the First World War, and it had serious social consequences. Thus, at first the number of young children on the estates was disproportionately high, clinics and nursery schools were badly needed but not always available, and the infants' and junior departments of the schools were crowded out. As the years went on these extra numbers were to be found in the senior schools, and later in the juvenile labour market, while the numbers in the infant schools declined.[1] Meanwhile, families which, when the children were young, could reasonably be accommodated in the standard three-bedroomed houses (which in any case formed far too large a proportion of all houses built) outgrew them as the children became older, and the nation-wide survey of overcrowding, carried out in the spring of 1936, revealed that in many areas the degree of overcrowding was greater in houses owned by local authorities than in privately owned houses. Moreover, this was due for the most part to the fact that large families were occupying normal-size dwellings, and not to any appreciable extent to sharing houses or sub-letting,[2] that is, it was a direct consequence of the change in size and age structure of the families concerned. Hence it is important that, when planning their estates and allocating their vacancies, local authorities should include within the proposed community people of all ages and families of all types, and make allowances for growth and change. Further, if a permanent community with a tradition of its own is to be created, special provision should be made so that when the children of the original tenants marry they can remain on the estate if they so wish. The advantages of bringing up children in a healthier environment cannot be permanent if on marriage the members of each new generation are forced back to the overcrowded or insanitary condition from which their parents were removed.[3]

[1] For a more detailed discussion of this question see *Population Problems of New Estates with Special Reference to Norris Green*, University of Liverpool Press, 1939, chs. vi and vii.

[2] Ministry of Health, *Report of the Overcrowding Survey of England and Wales*, 1936, p. xx. The percentage of overcrowding in houses owned by local authorities was 5·1, cf. 3·7 for privately owned houses.

[3] Cf. *Population Problems of New Estates*, p. 24. The author estimated that the number of young people of twenty and upwards who left the Norris Green estate between 1930 and 1937 was 1,550. This would presumably include many who migrated to other parts of the country in search of work or left for other reasons than the one suggested in the text.

The balancing of age groups is but one of the many problems which confront the planner when he passes from designing dwellings for families regarded as separate units to planning communities in which they can live socially satisfying lives. One of the most difficult of these is that of the class structure of the new community. The inter-war estates were often made up of families all of whom belonged to the same social class. This was particularly marked on the estates and blocks of flats built in the thirties to rehouse families from the areas scheduled for slum clearance under the Greenwood Act of 1930, and the grey level of poverty which characterised these estates was accentuated in some parts of the country by the long-term unemployment which was the curse of that decade. The glaring deficiencies of these estates and blocks of dwellings, with their lack of leadership, generally low economic and social standards, and high proportion of problem families, has led to a swing of opinion in favour of the mixing of classes, as it is thought this would be the best way of ensuring a balanced community with a rich and varied social life. It is not always very clear what exactly is meant by such mixing, but investigations which have been made into social relationships on existing estates indicate that there are serious difficulties in the way of bringing about a close integration of people of different standards and interests. Thus a survey of the Bristol housing estates made in 1939 showed that attempts to introduce families cleared from the slums among well-established artisan families led to the withdrawal of the latter. The conclusion of the authors of the survey was that the mixing of classes in very close proximity was resented for many reasons, and 'apart from a general improvement in standards, these difficulties can only be avoided by grouping tenants of similar habits in small though coherent sub-units'.[1] An almost identical conclusion was reached by Mr. Norman Williams as a result of his observations in Norris Green, Liverpool, in 1937. He writes: 'We have found that neighbourhoods flourish best in small clusters containing between forty and sixty houses, all at the same rent and with the same type of tenant',[2] while Dr. Dennis Chapman concluded from his investigations into the social relations of neighbours in different types of housing development in Middlesbrough that 'there is a good deal of evidence that the mixing of social class and other groups, including age groups, religious groups and even persons of different intellectual interest creates social friction'.[3]

[1] R. Jevons and J. Madge, *Housing Estates, a Study of Bristol Corporation Policy and Practice between the Wars*, p. 69.

[2] *Population Problems of New Estates*, p. 48.

[3] Dennis Chapman, *A Social Survey of Middlesbrough*, the Social Survey, New Series, No. 50, September 1945, Part IV, 'Social Relations', p. 16.

From the results of these investigations it would seem that, in general, members of different social classes do not make good neighbours, but this does not necessarily preclude them from combining to form a satisfactory community, such as may be found in a small town. Hence, when discussing the mixing of classes and other social aspects of planning it is necessary to observe the distinction between a 'neighbourhood' and a 'local community' which is masked by the present rather unfortunate use of the term 'neighbourhood unit'. As Mr. M. P. Fogarty puts it, 'Neighbourliness is mainly a matter of personalities and immediate day to day needs. It is a matter chiefly for people in the same social class living in the same street. The community spirit is on a much larger scale. It need not involve people dropping in to each other's houses or even necessarily knowing one another, and it should be broad enough to embrace people of widely different backgrounds and social classes. It is the feeling of belonging to a social group with common interests and responsibilities—a group in fact with a life of its own.'[1] The planner is thus faced with the double task of planning for both neighbourhood and community living.

Up to the present, attention has been focused in the main on the planning of communities, but proposals have been made for the creation of neighbourhoods in the true sense of the term. Thus the new town of Aycliffe, County Durham, is to be made up of housing precincts, or groups of about 100 dwellings arranged so as to encourage social activity and face-to-face contacts, and these, in their turn, are to be grouped into 'wards' of 400 to 500 houses. These wards are regarded as desirable social planning units, particularly for a small town, since they can support the number of shops required to meet everyday needs, are an advisable size for a nursery school, and can be supervised by a single housing manager. Thus in the Aycliffe Plan the group based on neighbourly relations is basic, but the somewhat larger unit, that based on daily needs, is also given its place.

The 'precincts' proposed for Aycliffe closely resemble the 'greens' of the better-known Reilly plan.[2] This plan proposes that the majority of houses in a particular area should be built round 'greens' of 30–60 houses, while the greens themselves would stem, 'like the petals of a flower', from a community building. As elaborated by Mr. Lawrence Wolfe, the community services included in

[1] M. P. Fogarty, *Town and Country Planning*, p. 110, cf. Ruth Glass: 'The community is characterised by common ideas, the neighbourhood by common social contacts in a limited geographical setting.' *The Social Background of a Plan*, p. 19.

[2] The plan was originally designed by Sir Charles Reilly, at that time Professor of Architecture at Liverpool University for the Birkenhead County Borough, but was rejected by them in favour of a more conventional approach.

this planning would include a nursery and nursery school for each green, and a restaurant and meals service attached to the community centre, which would obviate the necessity of cooking for those who did not wish to do it. Mr. Wolfe's objective would seem to be a gradual replacement of the old 'isolationist' way of life, centring round the family home, by a new form of group life in which the spontaneous co-operation of neighbours in their non-vocational daily life would be so great that the green and its associated amenities would become a virtual extension of the home. In his enthusiasm he seems sometimes to lose touch with reality. More recent surveys have demonstrated the importance many families attach to 'privacy' or the power to avoid too intimate social contacts with neighbours, which may lead to friction and unhappiness rather than co-operation unless the persons concerned feel they can be controlled.[1]

For the last few years the generally accepted basis of planning has been the misnamed 'neighbourhood unit' or small community. These units are intended to be microcosms of society as a whole, and it is suggested that they should consist of approximately 10,000 people or 2,000 families, and include people of differing ages, occupations, interests and classes. Each unit is designed to be as self-contained as possible, separated from the rest by main roads, and turning inward to the 'neighbourhood centre' which would be the shopping centre for the neighbourhood and include such facilities as a health centre and a community centre. The 'neighbourhood' is also expected to support its own nursery, primary and secondary modern schools, playing fields and open spaces, churches of various denominations, public houses and the other amenities which are regarded as essential if the day-to-day needs of the inhabitants are to be met. It is thus an attempt to create a community on the basis of common institutions and common interests.[2]

Although there has been a good deal of 'neighbourhood planning' of recent years, as yet no complete unit has been built and occupied over a number of years, so the whole conception has not been tested in practice. It has, however, already been subjected to a good deal of criticism. One of the major criticisms levelled at it is that it is based on home and leisure time needs and interests, and is not related in any way to the working lives of its inhabitants. 'Neighbourhood units' are sometimes described by

[1] L. Wolfe, *The Reilly Plan.* Cf. L. Kuper, *Living in Towns*; Universities of Liverpool and Sheffield, *Neighbourhood and Community.*

[2] Thus the City Architect of Manchester writes: 'The neighbourhood unit is a modern urbanised version of the traditional village and the counterpart of the village green is the neighbourhood centre incorporating the community centre, local shops, churches, and public house, a bank, library and health centre.' *City of Manchester Plan,* 1945, p. 135.

their advocates as the modern equivalents of the old village communities, but one of the closest bonds uniting the inhabitants of the village was that of similar or related occupations. Now, however, the work-place and the home are often widely separated and the link between them a very tenuous one, so that people living in the same neighbourhood may work in different trades in different parts of the city. Thus it would seem that modern man has to make a choice between two bonds of association—that of locality and that of common employment. Moreover, the growth of communications combined with almost universal literacy makes it possible for people to lead full and satisfying lives, in spite of having but few contacts with the people of their own neighbourhood. At the same time many people still live very narrow and often lonely lives, and opportunities for forming associations with others having common interests and living in the same area may help them overcome this social isolation, and if this can be encouraged by planning, something worth while will have been achieved.[1] Moreover, the feeling that one belongs to a local community, in the life of which one can play a significant part, and for which one develops a sense of responsibility, is the foundation of local democracy and good local government.

Another controversial issue which has arisen in connection with 'neighbourhood planning' is the extent to which the separate units should be self-contained. Thus the generally accepted idea of the maximum possible degree of self-maintenance by the provision within the 'neighbourhood' of all the services necessary for everyday living has been criticised as being too rigid. For example, the survey of Middlesbrough revealed a good deal of 'inflow' and 'outflow' in and out of existing neighbourhoods, which varied both with the type and situation of the neighbourhood and the nature of the institutions considered, whether they were, for example, schools and of what kind, shops and of what kind, churches, public houses or other services to meet ordinary needs. It would appear from this investigation that 'the choice of institutions we frequent is not subject to distance alone, but to a variety of additional considerations and characteristics', and the investigators conclude that 'convenient access to institutions is essential, but standards of convenience vary for different groups and for different types of services. There will inevitably be a good deal of criss-cross movement and residential cells should therefore be closely related to each other. The pattern of urban areas should express and facilitate the coherence of groups of neighbours, it should not be split up

[1] E.g., for further discussion see *Planning*, Vol. XV, No. 296—'Can Communities be Planned?' also the discussion on community centres and associations in Chapter XX.

by a number of sub-divisions.'[1] Neighbourhoods are not separate entities, they are parts of a larger whole, the town or city itself, and this should be emphasised. Planning of neighbourhoods is thus incomplete in itself, it must form part of the ordered planning of the whole town.

Town planning is not new. Most of the towns and villages of pre-industrial England grew slowly in response to the social and economic needs of their inhabitants, but a few were deliberately planned. Such planning as there was, however, was mainly for the benefit of the middle and upper classes, and except perhaps for groups of almshouses for old people, the needs of the workers, at any rate in the towns, were hardly considered. During the Industrial Revolution towns were allowed to grow without let or hindrance, and the insanitary chaos which resulted in many, if not all, of them, led finally to the public health measures already described in Chapter IV. Thus, throughout the greater part of the nineteenth century, town planning was primarily a question of public health, and although minimum standards of health and housing were established, it was at the cost of the creation of whole districts of dreary streets with little to break their monotony. Moreover, no attempt was made to regulate the growth and spread of the towns, or to prevent the intermingling of factories and dwellings. One or two far-seeing idealists, such as Robert Owen, made plans for building village communities which would relieve the overcrowding in the towns and provide healthy living conditions for the artisans, but they came to nothing. During the latter part of the century certain industrialists, of whom Titus Salt of Bradford was the first,[2] removed their factories from congested areas in the towns and built them in the country, surrounded by model villages intended primarily for their workers, and the success of schemes such as Port Sunlight, founded in 1887, and Bournville[3] which was started in 1889, prepared the way for the wider conceptions and greater achievements of twentieth-century town planning.

A new era, in which people began to plan for social living instead of simply for health, dawned when Ebenezer Howard produced *Garden Cities of To-morrow* in 1898. He insisted that these cities should be limited in size so that the inhabitants could live near their work yet be within reach of the open country,[4] and that each

[1] Ruth Glass, *The Social Background of a Plan*, p. 43.

[2] He started to build his model village, Saltaire, in 1851.

[3] Bournville was planned not only for the benefit of the work-people employed by the Cadbury brothers, but for 'the working classes and labouring population in and around Birmingham', and in time the estate was handed over to the Bournville Village Trust.

[4] Howard suggested that the maximum population desirable for any one garden city was 32,000.

town should be surrounded by a 'green belt' of agricultural land. It was also an important part of Howard's plan that the garden cities should be genuine towns with their own industries, and not simply residential suburbs, but they must be so planned that the industries would be grouped together in their own 'zone', and the intermixture of industrial, commercial and residential buildings avoided.[1]

Howard's principles were first put into practice at Letchworth[2] and later at Welwyn Garden City, both of which were promoted by private companies. For the most part the local authorities responsible for rehousing during the inter-war years ignored this method of preventing the over-growth of any one city, and emphasised the already existing suburban sprawl of their cities by siting new housing estates on the edges of the built-up area. There were, however, one or two exceptions to this policy, such as Manchester's satellite town of Wythenshawe and Liverpool's satellite, Speke. Neither of these are garden cities in the true sense of the word—they are too near their parent cities and too closely linked with them—but they are a considerable improvement on the ordinary housing estate.

Meanwhile, various aspects of the distribution of the changing population of the nation as a whole, particularly the drift to the south-east and the growth of the Greater London and other 'conurbations', were causing concern, and in 1937 the Royal Commission on the Distribution of the Industrial Population was set up under the chairmanship of Sir Montague Barlow. This reported in 1940 and proposed measures of decentralisation and dispersal, which however could only be properly co-ordinated by a Central Planning Authority. In 1943 the Ministry of Town and Country Planning was brought into being, and during the closing years of the war and those immediately following set to work to implement the main proposals of the Barlow Commission and its two complementary bodies, namely the Committee on Land Utilisation in Rural Areas (the Scott Committee),[3] and that on Compensation and Betterment (the Uthwatt Committee).[4] One of

[1] For a further discussion of these principles see *Garden Cities of To-morrow*, also F. J. Osborn, *Green Belt Cities, the British Contribution*, 1946.

[2] For a study of the early development of Letchworth, see C. B. Purdom, *The Garden City*, 1913.

[3] This reported in 1942.

[4] This Committee issued its Final Report in 1942. Its business was to consider the highly technical questions arising in connection with the necessity for compensating landowners for the changes in the actual or potential value of their land occurring or likely to occur as a result of planning. In some cases the value of the land was raised, in which case the owners were expected to pay 'betterment'; in others it was lowered owing to restrictions on building or other developments, and compensation was given.

the projects which emerged from this activity was the proposal to create 'new towns' to relieve the congestion of the existing centres of population, and the planning of such new towns is now taking place on the lines laid down by the New Towns Act. As the name suggests, these towns are to be independent centres from the start. During the initial stages of their development their affairs are managed by Development Corporations appointed by the Ministry of Town and Country Planning (now the Ministry of Housing and Local Government), but as each town is completed, its Development Corporation will be wound up, and the new town will be owned and governed by the people living in it.

Since not one of the new towns is yet complete,[1] the success or failure of this experiment in social planning is still a matter of conjecture. There has been some opposition from the people living in the towns or villages which will be incorporated into the new towns, and some criticism of the Development Corporations, while current economic difficulties are slowing down progress, but if the experiment can be carried through, and the new towns successfully established, in spite of these difficulties and set-backs, they will make a real contribution to the solution of the congestion and overgrowth of our large towns and cities.

It can be seen from what has been written that much has been accomplished, and more can be done to further the personal and social well-being of families transferred to new homes whether in blocks of flats, suburbs of existing cities or new towns. But for many years to come those for whom new houses can be built will form but a small proportion of those in need of better housing accommodation, and the new towns will only relieve congestion in the central areas to a very limited extent. Hence the question arises as to whether anything can be done to improve the lot of those who remain behind. Among those who are likely to have to wait long for better accommodation are those living in the inner areas of our big cities, in houses still fit for human habitation in the sense that they are not positively detrimental to health, but which are badly sited and planned, in a poor state of repair and lacking the amenities of more modern dwellings. These houses will probably continue in use for twenty years or more—'a short period in the development of a city, but spanning all the years of childhood for several generations of school children; a short time in terms of municipal investment, but long enough to cover the life of a

[1] For progress so far see Reports of the Aycliffe, Basildon, Crawley, Harlow, Hatfield, Hemel Hempstead, Peterlee and Welwyn Garden City Development Corporations. Published in one volume, H.M.S.O., 1950. See also Harold Orlans *Stevenage, a Sociological Study of a New Town.* Routledge & Kegan Paul, 1952.

family from the marriage of the parents until the children grow up and leave for homes of their own'.[1]

One of the greatest needs in these areas is for better and quicker house repairs.[2] Thus, an enquiry undertaken into one such area, revealed that this was one of the greatest grievances of the people living there, especially when they compared the condition of their houses with the high standards of equipment of those being erected on the estates.[3] The Housing Repairs and Rents Act, 1954, should do something to improve this situation since it provides house owners with financial assistance up to a maximum of £400 towards the improvement or conversion of their property, provided that the dwellings as improved will provide satisfactory accommodation for at least fifteen years.[4]

Repairs and improvements in the houses themselves are important, but insufficient in themselves to remedy the defects from which these areas suffer, especially as these defects are as much due to their planning or lack of it, as to the structure and design of individual houses. Prominent among such defects are the lack of open spaces, particularly play spaces for children, and associated with this, an almost universal drabness and ugliness. As we have already seen this is largely due to the fact that during the second half of the nineteenth century, when the nation was beginning to realise its responsibility for housing, objectives were still very limited, and all that was required was to secure minimum standards of health and decency. 'The operative word was drains',[5] and housing policy was dominated by all that drains symbolise. 'They' (i.e., the Victorian builders and planners) 'did not realise that they had cut off our people from the chiefest natural means of grace. They did not appreciate the curse and cruelty of ugliness.'[6] To-day we are feeling our way to a new conception of housing as a personal and social rather than a sanitary service, and to a greater apprecia-

[1] B. N. Stancliffe and Mary S. Muray, 'Till we Build Again. An Enquiry into Social Conditions in a Selected Area in Salford', *Social Welfare*, Vol. XII, No. 4, October 1948, p. 78.

[2] Ibid., p. 78. The present Rent Restriction Acts appear to militate against this, and might well be investigated and revised.

[3] Ibid., p. 81. For example, at a time when people in these areas were waiting 10–12 months for a new W.C. pan to replace one that was badly defective, two W.C.'s, one up and one down, were being put in the new houses.

[4] Ordinary repairs and maintenance are excluded.

[5] M. P. Fogarty, *Town and Country Planning*, p. 17.

[6] Alfred Salter quoted by Fenner Brockway in *Bermondsey Story*, the Life of Alfred Salter, 1950, p. 89. When the Salters began their campaign to beautify Bermondsey with trees, flowers and shrubs in 1923 the Council did not possess a single open space. The L.C.C. owned Southwark Park, but apart from this there was no relief for its 120,000 people from bricks and mortar. The Council started by planting flowers in the old churchyards.

tion of the need to create beauty, as well as to overcome squalor. Some of the implications of this approach have been discussed in this chapter, which has also given some indication of the problems involved in it. But considerable as these difficulties are, they are not insurmountable. With patient research and imaginative understanding of family needs and desires, and sufficient financial support, the planners can do much to overcome the defects of the past and create worthy homes and socially and aesthetically satisfying towns and neighbourhoods for the families of the future.

PART TWO

INDIVIDUALISING THE SOCIAL SERVICES

'Love does not cling to the *I* in such a way as to have the *Thou* only for its "content", its object; but love is between *I* and *Thou*. . . . In the eyes of him who takes his stand in love, and gazes out of it, men are cut free from their entanglement in bustling activity. Good people and evil, wise and foolish, beautiful and ugly, become successively real to him; that is, set free, they step forth in their singleness, and confront him as Thou. In a wonderful way, from time to time, exclusiveness arises—and so he can be effective, helping, healing, educating, raising up, saving. Love is responsibility of an *I* for a *Thou*.'—MARTIN BUBER.

CHAPTER VII

SOCIAL CASE WORK

THE opening paragraphs of this book stressed that the social services were brought into being to meet the personal needs of the individual citizen. Many such needs are common to considerable numbers of people, and in a complex society can only be met by large-scale community planning, such as has already been described. But social action of this type, although essential for individual and community well-being, is incomplete in itself. It may even defeat its own purpose, since, although the measures taken are designed to further the well-being of the individual, the pressure of numbers almost inevitably leads to mass techniques. Further, overmuch concentration on measures to secure minimum standards of health, decency and economic security may lead to underestimating the importance of personal attitudes and relationships. As Gordon Hamilton points out[1] economic well-being and social behaviour are so closely interwoven that 'No one can presume to understand a problem of poverty without some knowledge of human behaviour, and no one can treat a problem of human behaviour intelligently without reference to its economic and social frame work'. Hence the importance of the development alongside the collective social services of the technique known as social casework. This is concerned 'not so much to make the services as to help individuals to use them',[2] and emphasises that, although he has much in common with his fellows, the individual is and must always remain unique.

The principles underlying social case work and their resulting techniques were worked out during the closing decades of the nineteenth century by a group of men and women, including such well-known pioneers in social work as Octavia Hill, Canon Barnett and Charles Loch. These together built up an organisation known for many years as the Charity Organisation Society, now the Family Welfare Association, which was the vehicle of their

[1] *Theory and Practice of Social Case Work*, New York, 1940, p. 4.

[2] Una Cormack, 'Developments in Case Work', ch. iii, in Bourdillon (ed.), *Voluntary Social Services, their Place in the Modern State* and reprinted by the Family Welfare Association as a separate pamphlet.

philosophy and the means by which their principles were put into practice. In its early days the work of the Society centred round the problem of 'pauperism', the social and moral degradation of the poverty-stricken and unemployed, which the founders of the Charity Organisation Society believed to be more serious than poverty itself. In their view this state of affairs was largely the result of unwise attempts to mitigate poverty by indiscriminate charitable relief, which undermined the deterrent effects of the Poor Law and encouraged the careless and undeserving. Underlying this diagnosis of the situation was the belief that in the vast majority of cases personal inadequacy of one kind or another was the main reason for the family's failure to remain independent and self-supporting. Hence, while the Charity Organisation Society campaigned actively for certain specific projects for social betterment, such as the provision of tuberculosis dispensaries and the care of the feeble-minded, it opposed the provision of any form of State assistance which might undermine individual or family responsibility. The Society believed that pauperism could only be diminished by the restoration of individuals and families to self-respect and independence, and the only way of accomplishing this was by treating them separately, endeavouring to understand the causes of social inadequacy in each case and findingways of remedying them. In their diagnosis the Charity Organisation Society underestimated the part played by economic factors outside the control of the individuals concerned, in the causation of poverty.[1] Nevertheless, the personal factors they emphasised were relevant, and even if, as a later generation came to believe, society can overcome many social ills by policies designed to reduce unemployment and secure a minimum standard of life for all, personal problems and inadequacies remain. Perhaps the chief contribution made by the Charity Organisation Society to social progress was its evolution of a technique with which these can be tackled.

The principles on which all forms of case work are based are derived from the belief that man is 'a responsible self-determining creature', whose needs are not only material, but spiritual, and whose personality must be respected and co-operation secured in any plans made to deal with the situation which has led him to seek for help. Hence, his relationship with the case worker and the agency she represents must be such that he is 'free to be himself, without shame or guilt, to tell the truth, to accept or reject the help offered, and to co-operate in establishing his rights or in following

[1] This was brought out by the findings of Booth and Rowntree described in Chapter II above. See also the criticisms of the Charity Organisation Society made by Beatrice Webb, *My Apprenticeship*, ch. iv and her comments on 'The Irrelevance of Charity' in ch. v of the same book.

out a jointly determined policy, all of his own free will'.[1] The help given may include some form of material assistance, and the giving of such relief still plays an important part in the work of some agencies, but according to case work principles such help must be regarded not as an end in itself, but as part of the whole process of social rehabilitation. Consequently when given, it must be adequate in amount, suitable to the needs of the client and given in such a way as to foster rather than destroy the self-respect of both client and worker.[2] The main contribution the case worker has to make to the solution of the difficulty does not lie in the giving of alms, however, but in friendship,[3] a friendship which will support and strengthen the client, bring him to a better understanding of his difficulties, and enable him to take advantage of the community resources available to him. Consequently her outlook and attitude are all important and 'In the last resort the social worker has only one piece of equipment to work with, her own personality'.[4]

A worker-client relationship, in which the worker is able to put herself alongside the client and make him feel that they are facing a difficult situation together, is essential to proper case work, but there is another aspect of the situation which is equally important. The case worker is not merely a 'good neighbour', a 'friend', even an expert friend, of the family in distress. The basis of her relationship with the client is professional rather than personal, her contact with him for a specified purpose, which must never be lost sight of, and, while seeking to understand and appreciate the client's point of view, she must be on her guard against over-identification and too great emotional involvement. In all her dealings with the client she is acting not in a personal capacity, but as the representative of the agency, public or voluntary, to which, rather than any individual, he first came for assistance; while through this agency she acts as his link with the community as a whole. Thus she is responsible to her agency and to the wider community as well as to the client, and is bound for the purposes of her work by the policy and functions of her agency and the accepted standards of community care of the society of which she and the client are members. In her capacity as citizen the case worker may seek to improve these standards, and case work organisations as such have a responsibility for bringing to public and government

[1] Una L. Cormack, 'Principles of Social Case Work', *Social Work*, Vol. IV, No. 3, July 1947, p. 71. In certain forms of case work such as probation there is an element of compulsion. The effects of this are discussed below, p. 116.

[2] T. Stephens, *Problem Families*, 1945, p. 52.

[3] This is, of course, an extension of Octavia Hill's well-known aphorism that charity is 'Not alms, but a friend'.

[4] Roger C. Wilson, 'Aims and Methods of a Department of Social Studies', *Social Work*, Vol. VI, No. 4, October 1949, p. 358.

notice deficiencies and anomalies in social legislation and so securing remedies for them,[1] but while dealing with individual cases the worker must accept the limitations of the situation and work within them.[2]

The general principles discussed so far are basic to all forms of case work and are as valid now as they were in the early days of the Charity Organisation Society, but during the eighty years which have elapsed since then many changes affecting the scope and character of the work have taken place. The most important of these are, first, the assumption by the State through its comprehensive health, social insurance and assistance schemes, of direct responsibility for meeting the basic material needs of its citizens; second, the growing recognition that good human relationships are as fundamental to the happiness and well-being of the individual as good material conditions. The third is the extension of the application of scientific method from the study of the physical world to that of the individual and of society, which has resulted in a more detached or 'non-judgmental' approach to the client by the case worker trained along these lines. These developments have been accompanied by changes and specialisations within case work itself, and a growing appreciation of the applicability of its techniques within a wide range of public and voluntary social services, so that the present century has witnessed the growth of medical-social work, probation, child-care and psychiatric social work, all of which are based on case work principles. A further significant modern development is the growing realisation that, while the statutory social services designed to meet the basic needs of individuals, such as the National Assistance Board, may 'develop and administer a sound system of social service which pays its beneficiaries all the respect due to them as citizens of a democratic society without necessarily attempting to give each beneficiary the detailed comprehensive consideration which is the distinguishing feature of case work', at the same time 'case work principles must be embodied in the structure of the services and case work services made available to those who need them'.[3]

The growth of the statutory services and the development of

[1] For example, the evidence of the Charity Organisation Society provided about the difficulties people got into in connection with hire purchase contributed to the bringing in of the Hire Purchase Act, 1938. Similarly, prior to the 1949 Adoption Act, case work organisations provided evidence in connection with legal aspects of adoption.

[2] For an example of the tension which may arise between loyalty to the policy of the agency and a desire to help the client see 'Dane, a Study in Family Life', *Social Work*, Vol. V, No. 4, October 1948, pp. 211–18 and the comments in the following number.

[3] Cherry Morris (ed.), *Social Case Work in Great Britain*, 1950, pp. 29–30.

specialised forms of case work each with its somewhat differing emphasis and technique, have not done away with the need for the general agency of the type created by the Charity Organisation Society. Just as the need for the general practitioner persists in spite of the multiplication of medical specialists, so does the need remain for the social agency whose endeavour it is to help all cases of distress.

Agencies of this type, which are generally known as family case work agencies, are found in large centres of population throughout the country. With one exception, Chesterfield, where the local authority has assumed responsibility, they are voluntary organisations and are independent of each other.[1] Many are affiliated to the National Council of Family Welfare Agencies, which was established in 1948 as a co-ordinating body 'to formulate a policy for, and to promote the development of, family case work and establish standards of work and training'.

The work of a family case work agency is so varied and the problems brought to it so diverse, that it is difficult to summarise them in a few sentences.[2] To the agency come people in need of material help such as clothing, furniture or bedding; people involved in legal difficulties such as those which arise between landlord and tenant; people with family problems ranging from adoption to matrimonial difficulties; people in doubt about their position with regard to some form of social insurance or assistance, or who are aggrieved because they think they have not obtained their rights, and many others—lonely, stranded, puzzled, unhappy and despairing. Moreover, as the case worker listens to the lengthy and often incoherent stories told her by her clients she often finds that the problem brought to her for solution is not the real difficulty. Involved in it may be a number of others, perhaps more fundamental and frequently involving other members of the family, and it may take weeks and months, or even years of skilled and patient work, before they can be overcome and the family set on its feet again.

Two main features characterise the work of family case work agencies. First, as the designation implies, they are concerned not only with individuals but families. The person seeking assistance is regarded not simply as an individual, but as a member of a family group, and, in considering the help or advice to be given,

[1] Some function as completely independent bodies, others as part of the work of local Councils of Social Service. The functions of Councils of Social Service are discussed in Chapter XXI.

[2] For a clear description which includes useful illustrative material, see ch. iii in Cherry Morris, op. cit. It is written by Miss D. M. Deed, then Training Secretary, Liverpool Personal Service Society.

the case worker must keep in mind the effect it might have on family relationships and well-being, since her aim is to preserve the integrity of the family unit as far as possible.

The second distinguishing feature of family case work is the close liaison maintained with all the statutory and voluntary bodies concerned with every type of social service. Families coming to the agency for assistance may be found to be in need of help which only a specialist body can give, and are then referred on, while, on the other hand, a specialist agency confronted with a problem outside its scope will refer the case to the family agency. Many cases demand the joint efforts of a number of agencies for a solution of their problems, however, and in these circumstances the family case worker has a special responsibility for keeping in mind the situation as a whole, and endeavouring to co-ordinate the efforts of the various specialists, so that overlapping and conflicting policies can be avoided as far as possible.[1]

The range of work undertaken by a family case work agency is very wide, and in addition to the intensive personal work with individuals and families which is their central function, some agencies undertake Citizens' Advice Bureaux, Poor Man's Lawyer and other kindred services. The majority act as almoners for national benevolent funds, while those recognised for the purpose give practical social-work training to students from University Social Studies Departments, the Home Office and the Institute of Almoners. A good family case work agency thus makes a valuable contribution to the life of the community which it serves. Unfortunately, many such agencies are handicapped by financial difficulties and staff shortages, and are unable to develop their work as intensively or extensively as they would like. The nature of the problems brought to them is changing, but their numbers show no signs of diminishing, and since they are often problems of adjustment and relationship, or relate to problem families who cannot, unaided, take advantage of specialist services, they frequently demand long-term and very skilled work. If family case work agencies are to keep an ever-open door to those in need of advice or assistance, means of overcoming their financial and administrative difficulties must be found.

Case work principles and methods were first used in dealing with miscellaneous family problems, particularly those associated with poverty and economic dependence, but as time went on it was recognised that they could be applied with particularly good effect to meet the needs of special categories of people, and case workers

[1] Liverpool Personal Service Society Inc., Annual Report, 1946–7, p. 4. The question of co-operation between different agencies undertaking case work is discussed below, Chapter XXI.

would function usefully within the framework of institutions such as hospitals and courts, and so the specialised categories of case work came into being. One of the most important applications of case work methods is medical social work, or almoning as it is more generally known as in this country, by means of which specially trained social case workers co-operate with the doctor in the diagnosis and treatment of illness by helping those who are sick with their personal and social problems.

The work started in a very modest way in 1895 when Miss Mary Stewart, a social worker trained by the London Charity Organisation Society, was established as the first hospital almoner in a 'dingy, dark, unventilated corner' of the out-patient department of the Royal Free Hospital, London. Her principal duty, as laid down by the Hospital Board, was 'to prevent abuse of the hospital by persons able to pay for medical treatment', but Miss Stewart was imbued with more positive aims, and sought to create a constructive service based on the adaptation of case work principles to meet the special needs of hospital patients. Thus, from the first, there was some discrepancy between the functions of the almoner as envisaged by the hospital boards and committees and those same functions as envisaged by the almoner herself. In spite of this difficulty, which was not solved until the National Health Service Act relieved hospitals of their financial responsibilities, almoning gradually established itself as a recognised branch of social work, and trained almoners were appointed in increasing numbers, not only in hospitals, both voluntary and municipal, but during the inter-war years in public health departments, particularly in connection with clinics for tuberculosis and venereal disease. The social dislocation of the war years helped the Ministry of Health and local authorities to realise that in many cases of illness social causes are as important as physical ones, and social care as necessary as medical treatment.[1] Hence, by the time the National Health Service Act came to be passed it was widely recognised that the medical social worker had a part to play in the comprehensive health service which was being created.

The National Health Service Act came into effect in July 1948, and in the following September the Minister of Health issued a circular to Boards of Governors and Hospital Management Committees outlining his views on the effect of the passing of the Act on the functions of the almoner.[2] The circular points out that with

[1] For further discussion of these war-time developments, see R. M. Titmuss, *Problems of Social Policy*, pp. 471–2.

[2] Ministry of Health Circular H.M.C. (48) 53, B.G. 48 (57). See also circular 160/48 to County Councils and County Borough Councils. These circulars are reviewed in an article called 'Another Milestone' in *The Almoner*, Vol. I, No. 7, October 1948.

the passing of the National Health Service Act the almoner has been freed from assessment duties and can now 'engage fully in the important medical social work for which she has been especially trained'. According to the Ministry this work consists of co-operation with the medical staff in their treatment of the patient, which co-operation should include social investigations and interviews to provide understanding of his social and personal background; social action during his illness to minimise personal anxieties, family difficulties and other problems; and finally the making of arrangements with local Health Authorities concerning home visiting and after-care.

The circular was obscure on one or two points, and its references to home visiting and after-care showed that the distinction between the approach of the health visitor who, although she works through personal relationships has as her main task the improvement of standards of hygiene, and the almoner who 'not only works through personal relationships but is directly concerned to adjust personal relationships in so far as they have a bearing on the client's health',[1] was not altogether appreciated. In general, however, it showed that the Ministry realised that if treatment is to be fully effective the patient must be considered as a person in a social situation, and not merely as a case of a particular disease. This has always been the approach of the best type of family doctor, but during the 'machine age of medicine' when scientific discoveries focused attention on the physical causes of illness it had been rather lost sight of, especially in hospital wards and out-patient departments.[2] Now, however, the importance of social and psychological factors in the causation of disease is becoming increasingly widely recognised. Diagnosis is no longer regarded as a purely physical investigation, and treatment is seen to involve social rehabilitation as well as physical therapy. These developments necessitate the inclusion of the almoner as a member of the medical team, for she provides the link between the hospital or clinic and the patient's personal and working life. As such she must co-operate with doctors and nurses on the one hand, and on the other maintain close contacts with social workers and others outside the hospital who are in a position to influence the welfare of the patient. These will include, for example, family case workers, personnel managers, disablement resettlement officers, and in the case of a child, his teacher, school nurse or welfare officer. Last

[1] *Social Work in the New Health Service*, a pamphlet published by a group of social workers who are members of the Socialist Medical Association, p. 6.

[2] Jean Snelling, 'Medical Social Work' in Cherry Morris, op. cit., pp. 80–1. For a full discussion of the developments discussed above as seen by an American physician, see Henry B. Richardson, *Patients Have Families*, Commonwealth Fund, 1945.

but not least, there is the patient's own family, whose attitude will do much to hasten or retard his recovery, or in the case of permanent disability help or hinder him in making an adjustment.

The status and functions of the almoner working inside a hospital are now firmly established, and local authorities, who for some years have been employing almoners in connection with the treatment of tuberculosis and venereal disease are now beginning to use them in their general preventive and after-care services.[1] There is, however, one sphere of medicine into which as yet she has hardly penetrated, namely general practice. Planners may include her as a member of staff of one of the health centres of the future, but many doctors have still to be convinced that there is a place for her in the personal practitioner service. During the next few years there should be opportunities for experiments to be made in this field. A beginning has been made in some places, for example, in the general practice created by the Department of Public Health and Social Medicine, Edinburgh University, on the basis of the old Royal Dispensary. In certain respects the situation here is unique, particularly as the practice is closely associated with the teaching and research carried out at the University, but it has been found in this practice that 'a family doctor team' consisting of a doctor, an almoner and a health visitor can function successfully, and is acceptable to patients.[2]

In general it would appear that medical-social work is becoming recognised as an integral part of all branches of the health service. Not all patients using the service will need intensive social case work in connection with their medical treatment, but the experience of the last fifty years suggests that many, perhaps more than one would expect, are likely to have underlying personal anxieties and personal and family problems which contribute to their ill-health or hinder their recovery, and which a trained medical-social worker can help them overcome. In helping these individuals the almoner will also have opportunities of learning more of the contribution of social factors to health and disease and of making her special contribution to the developing discipline of social medicine.

Medical-social work is one example of the successful adaptation

[1] For a brief account of these developments see J. Ruth Horton, 'The Work of the Local Health Authority Almoner', *The Almoner*, Vol. III, No. 4, July 1950, p. 133.

[2] Richard Scott, 'A Teaching General Practice', *Edinburgh Medical Journal*, Vol. LVII, pp. 454–77. See also articles by R. Scott and the almoner who works with him, Miss J. E. Patterson, in *The Almoner*, January and February 1949. On the question of familiarising medical students with the purposes and methods of medical social work, see Jane E. Patterson, 'The Almoner's Contribution to Medical Teaching', *The Almoner*, August and September 1950.

of the general principles of case work to meet the special needs of a particular category of people, and it also demonstrates the ability of the case worker to find her place within the framework of a rather rigid institution—in this instance the hospital. Another example of such adaptation is that of probation, in which the case worker functions within the framework of the judicial system. The function of the probation officer is to 'advise, assist and befriend' those offenders who are placed under his supervision by the court, the intention being that he shall bring about their transformation from delinquents into law-abiding citizens. The methods he uses are fundamentally those of all case workers, but as Mr. W. G. Minn shows in his contribution to the symposium *Social Case Work in Great Britain*, the legal framework in which the work is necessarily carried on imposes certain conditions to which the officer must adapt himself and his methods. Thus the conflict between the demands of the client and the interests and attitudes of the community, which, as we have seen, may create tensions in all forms of social work, is here particularly clearly marked. While in the majority of case work situations the client approaches the agency of his own free will, and may accept or reject the help offered, or terminate the contact if he so pleases, in probation there is an element of compulsion. It is true that, except in the case of a child under the age of fourteen, the consent of the offender must be obtained before an order is made, but this may be little more than a formality, since the alternatives are likely to be even more disagreeable. Further, throughout the period of probation the offender knows that, should he fail to be of good behaviour and comply with the conditions of his order, he may be brought back to the court by the officer and punished for the original offence. Probation is a suspension, not a remission, of sentence, and the probation officer has behind him in his dealings with his client the full force of the law. It has been suggested[1] that this support involves an inherent weakness, since 'the use of power will frustrate whatever goodwill has been built up by patient work between individual and individual'. Hence, a probation officer 'will do his utmost to leave the law in the background and try again and again to establish a relationship based on trust, encouragement and persuasion'. There is much truth in this, but as Mr. Minn points out, many delinquents placed on probation have 'an inadequate sense of reality' and 'the officer's first task is to help them accept life as it is'. If he is to accomplish this task successfully the officer must give the offender a real understanding of his own status and functions from the start, including an appreciation of the fact that it is his duty to report breaches of the probation order to the court. Experience

[1] Max Grunhüt, *Penal Reform, a Comparative Study*, 1948, p. 309.

has shown that when this situation is honestly faced and the position clearly established, 'it does not in fact militate against successful case work'.[1]

The methods used by probation officers in furthering the social rehabilitation of their clients are, like all case work methods, adapted to suit the age, personality, social and family background of the client. The officer adjusts his technique to the client's needs, and encourages the latter to help himself whenever possible, but is ready at need to support the weak, restrain the reckless and bring home to the careless and indifferent a sense of their responsibilities. Close co-operation is maintained with other social workers, and in the case of a child the co-operation of parents and teachers, as well as that of the offender himself, is essential for the success of the work. All this demands time, thought and patience, and if probation work is to be successful it is essential that the officer's case load should be reasonable and the conditions of work good. Further, magistrates must have a real understanding of the nature of the work, and not burden the probation officer with obviously unsuitable cases, or make his task impossible by attaching unworkable conditions to probation orders. There is also a need for more hostels where, in certain cases, short periods of residential care can be combined with probation, and the probation officer is further hampered in his work by such difficulties as the housing shortage and the inadequate provision of recreational facilities such as clubs and playing fields.

The success of probation as a method of dealing with delinquents is difficult to assess, but the increasing use made of it, not only in this country but in many parts of the world, indicates that it is becoming widely recognised that the constructive use of a personal relationship is one of the most fruitful ways of reclaiming the delinquent and anti-social. Even if the success of probation were no greater than that of harsher measures, something would be gained by its use wherever suitable, since probation 'is a superior method of treatment which does not disrupt a man's life, but pursues its object by preserving, if not rebuilding, his social relations with his personal environment'.[2]

Medical-social work and probation are two examples of the adaptation of case work methods to widely differing situations. Other examples, such as psychiatric social work and work with deprived children, are discussed in their appropriate contexts later in the book. Workers in these differing fields retain the underlying principles of case work, but modify them to meet the particular conditions of their work. There are indications that these differ-

[1] W. G. Minn in Cherry Morris, op. cit., p. 135.
[2] M. Grunhüt, op. cit., p. 311.

ences between the various types of case work are tending to widen, and this has resulted in some concern lest case work is becoming too departmentalised.[1] Social workers, who, above all people, should regard their clients as persons, whole and indivisible, are in danger of thinking of them as bundles of social needs, each need to be met by a highly skilled specialist. Hence, in spite of real efforts at co-operation, there are still too many persons and families who are in touch with several agencies, or transferred in quick succession from one to another with unsettling results. There is much to be said for the suggestion now being put forward that we should train and appoint more general case workers, particularly in rural areas and small towns, and reserve the specialists for cases in which particularly skilled handling is required, but its implementation might be difficult.

The question of specialisation is but one of the important issues facing those concerned about the future of case work. Another matter which is causing some anxiety is that of the recruitment and training of workers. At present the numbers of case workers of all kinds fall far short of the demands made for their services, and sufficient men and women of the right intellectual calibre and qualities of personality are not being trained to meet the needs of the future. This is a question which is outside the scope of this book,[2] but it has serious and far-reaching implications. More than any other profession, except perhaps teaching, case work depends for its success on the quality of its workers, and the work can only continue and develop if there are sufficient men and women of sound judgment, mature and balanced personality, and real insight into the needs of others, who will come forward to act as the community's agents in its concern for those who cannot adjust themselves to the complexities of living without individual advice and assistance.

[1] See for example the concluding chapter in Cherry Morris, op. cit., which is written by Eileen Younghusband of the London School of Economics; also the chapter on the 'Training and Recruitment of Social Workers' by Mrs. Gertrude Williams in *Voluntary Social Services since 1918*, particularly pp. 242–3.

[2] See Eileen L. Younghusband, *The Employment and Training of Social Workers*, Carnegie U.K. Trust, 1947, and *Social Work in Britain*, a Supplementary Report on the Employment and Training of Social Workers, 1951.

CHAPTER VIII

ADVICE FOR THE CITIZEN

THE principal function of the family case work agency is that of helping people to overcome their serious personal and social problems, but such agencies are frequently confronted with requests for miscellaneous information and advice on immediate difficulties. Nor are they alone in this; trade union organisers, political party agents, clergymen, teachers and doctors are all consulted by the puzzled and ignorant enmeshed in tangles of red tape, or at a loss when faced with the intricacies of an official form. Much general advice is still being sought and given in this way, but many areas now have Citizens' Advice Bureaux which have been set up for the specific purpose of answering the citizen's questions and dealing with his difficulties, and where established, such Bureaux have proved to be of great value.

The Citizens' Advice Bureaux were started to deal with difficulties likely to arise as the result of the impact of war on civilian life. When it became clear that the Second World War was imminent, experienced social workers and administrators realised that the dislocation of personal and family life likely to ensue, and the inevitable increase in the amount and complexity of government control, would necessitate a more systematic advice and information service than existed at the time, particularly in the target areas. Plans were prepared, and on the initiative of the National Council of Social Service, acting in co-operation with local individuals and organisations, Citizens' Advice Bureaux providing 'a free service of advice to every citizen' were started in centres of population throughout the country.[1] Where a case work agency or Council of Social Service existed in the locality the new service might be established under its auspices, but Bureaux were needed in many places where no such organisation existed,

[1] A useful account of the work of Citizens' Advice Bureaux and their role in contemporary society is given in *Advising the Citizen*, a Handbook for Workers in Advice Services. It was prepared by the Central Committee of Citizens' Advice Bureaux and published by the National Council for Social Services in June 1948.

and in these areas the officials of the National Council of Social Service encouraged the formation of *ad hoc* committees to be responsible for their establishment and maintenance. These committees were made as representative as possible of the varying interests, statutory and voluntary, religious, political and general in the area, for it is a cardinal principle of the Citizens' Advice Bureaux Service that 'a Citizens' Advice Bureau should be organised by the community for the community', and should recognise no differences of class, race or creed.

Local committees and Bureaux are autonomous, but the National Council of Social Service advises and assists them in various ways. Until October 1950, when the withdrawal of the government grant to the National Council made economies of staff inevitable, each region had its own travelling officer, who advised Bureaux secretaries on administrative questions such as finance, publicity, the best means of maintaining co-operation with other statutory and voluntary services and the training and recruiting of voluntary workers. These have now been withdrawn but the central office of the Council still maintains a useful Information Service, which among its other activities issues and keeps up to date that mine of information on current legislation—Citizens' Advice Notes.

The Citizens' Advice Bureaux movement was in origin a voluntary one, and while close co-operation has been established with central and local government departments, it has, except in certain areas, where the Bureau functions within the Local Authority Information Centre, remained as such. This is an advantage in many ways. Citizens' Advice Bureaux set out to give not simply information but advice, and it is considered essential that not only should this advice be disinterested, and as far as humanly possible free from bias of any kind, but that it should be known to be so. This would not be easy if the Bureaux were maintained as part of the machinery of government, whether central or local, especially as many enquirers come to the Bureaux because they are dissatisfied with the treatment they have received at the hands of a government or local authority department. In these cases the independent status of the Bureau is particularly important, since it enables the adviser to see both sides of the question, and balance the demands of the individual, who is inclined to stress his own particular needs to the exclusion of all other considerations, and the decision of the authority, which is based on general considerations of community welfare. The independent status of the Bureaux also enables advice to be given in personal problems and in cases 'in which it would be improper for a local authority to advise, since if it did so it would be intervening in issues which lie

between the private citizens, and helping one as against the other'.[1]

The voluntary character of Bureaux, valuable as it is considered to be, has its disadvantages. In particular it has meant that the work of some Bureaux has been hampered by financial and associated difficulties, such as that of obtaining adequate and suitable premises or sufficient equipment.

In the early days of the war, official recognition was given to the Bureaux service by a dual-purpose grant from the Ministry of Health. This was intended both to help in the establishment of individual Bureaux (to whose funds local authorities might also contribute under Civil Defence Powers), and as a contribution towards the cost of central and regional services provided by the N.C.S.S.

Grant-aid for the former purpose was discontinued in 1945 when the Ministry of Health (in Circular 197/45) gave local authorities powers to provide an information service, either directly or through a voluntary agency such as a C.A.B. These powers were subsequently confirmed in the Local Government Act, 1948 (Section 134), and are those under which, apart from the considerable number of authorities taking full financial responsibility for Bureaux, something like £35,000 a year in cash grants and a very great volume of help in kind, for example, in premises, equipment and personnel, are given to others. The grant for central services was continued year by year, and together with an allocation from the voluntary funds of the National Council of Social Service, provided a national headquarters organisation, an information service and the C.A.B. field officers. In 1948 the grant was substantially increased in view of the increased cost of the service.

It was therefore a very serious blow to the National Council to receive, at the end of the first month of the financial year 1950, an intimation of the reduction of that year's grant by 50 per cent and of its discontinuance thereafter. This leaves the central organisation with considerable financial difficulties.

The number and character of the enquiries brought to the Bureaux have varied and still vary according to place, times and circumstance. Since the service was established to meet the emergencies of war, it was natural that during the war years difficulties arising from war-time conditions should predominate. It quickly became clear, however, that even then many other matters were troubling citizens sufficiently to bring them to the Bureaux. Citizens' Advice Bureaux workers found themselves confronted with requests for information and advice about hire purchase, old age

[1] N.A.L.G.O. Report on Relations between Local Government and the community quoted in *Advising the Citizen*, p. 36.

pensions, social insurance and family problems as well as with queries about evacuation, bomb damage, service pay and allowances, communications with persons in enemy countries and food and clothes rationing. As with other war-time services[1] it soon became evident that a service created primarily to meet an emergency was also meeting a permanent need, and although the number of Bureaux decreased after the cessation of hostilities, many of those which were discontinued were small Bureaux which had not sufficiently established themselves in the community they set out to serve. The number and variety of enquiries now received annually by Bureaux throughout the country, and the confidence placed in them by government departments, are strong indications of the efficiency and usefulness of the service.[2]

The confidence of the public in the quality of the counsel given at Citizens' Advice Bureaux is shown not only by the substantial number of enquiries which are brought to them, but also by the increasing readiness of men and women to ask for advice on serious personal difficulties. It is the general opinion of Bureaux workers that the proportion of enquiries in which advice rather than information is sought, and which may involve real case work before they can be solved, is growing.[3] The line between giving advice and undertaking case work is, as a matter of fact, sometimes difficult to draw, for 'an apparently simple query when followed up may reveal a complicated family tangle needing wise counsel and positive action'.[4] This raises serious difficulties especially in those towns and country areas where there is no family case work agency to fall back on if the problem to be dealt with is beyond the competence of the Bureau helpers, who are, more often than not, volunteer workers with little or no specialized training. Possible methods of dealing with this difficulty are under active consideration by the movement. It has been suggested[5] that in order to meet the needs of small towns and rural areas, general case work services might be developed on a regional basis, and should professional family case workers be appointed for this purpose, they would be available to assist and advise Citizens' Advice Bureaux workers. The training of their volunteer workers 'to help them deal with

[1] As for example the hostels for evacuated old people described in Chapter XVII below, and the Family Service Units' work with problem families outlined in the chapter which follows.

[2] Examples of this may be found in the Annual Reports of the National Council of Social Service.

[3] Examples of the various types of enquiries brought to Citizens' Advice Bureaux and the action taken to deal with them are given in Lord Beveridge, *Voluntary Action*, Appendix C, pp. 381–97.

[4] Liverpool Personal Service Society Annual Report, 1946–7.

[5] National Council of Social Service, *Advising the Citizen*, p. 47.

personal problems and to recognise when it is necessary to call in the help of a specialist worker'[1] is generally accepted as one of the most urgent and difficult problems confronting Citizens' Advice Bureaux and, indeed, other types of social services, and considerable thought is being given to ways in which this can best be achieved.

While much of the information and advice asked for at a Citizens' Advice Bureau is of a general or personal character, it is sometimes more technical, and, in particular, Citizens' Advice Bureaux and case work agencies are frequently confronted with problems for which legal advice, and possibly even court proceedings, are required if the client is to obtain his rights. If he can afford to consult a solicitor privately the client will be encouraged to do so, but in a large number of cases this is out of the question, and unless free or assisted service is available, the case goes by default. Recognition of the need for a nation-wide legal aid service to meet this need and to replace the rather limited existing voluntary services led to the passing of the Legal Aid and Advice Act, 1949, the object of which was 'to provide assistance in a more effective form in the conduct of civil proceedings, and legal advice for those of slender means, so that no one will be financially unable to prosecute a just and reasonable claim or defend a legal right'.[2] To attain this objective, the provision of both legal aid, that is, 'assistance in conducting or defending proceedings in the courts whether by remission of court fees, free legal representation, provision for the payment of witnesses' expenses and otherwise', and legal advice, that is, 'advice in legal matters, the drafting of documents and negotiations apart from litigation',[3] were considered necessary, and the Act includes both. However, as yet, only those portions of the Act which provide for legal aid in the High Court or Court of Appeal and proceedings remitted from the High Court to the County Court, have been implemented. The establishment of a legal advice scheme has been deferred.

The legal aid scheme brought into being as a result of the Act is administered by the professional organisation of the legal profession, that is the Law Society, under the general guidance of the Lord Chancellor. There are obvious objections to a state legal aid service, especially in view of the extent of statutory intervention in all departments of life, and the set-up provided by the Act seems the one best designed to further the interests of justice.

[1] National Council of Social Service, *Social Patterns*. Report of the British National Conference in Social Work, Harrogate, 1950, pp. 59–60.

[2] Legal Aid and Advice Bill, 1948. Summary of the Proposed New Service, Cmd. 7563, H.M.S.O., 1948, p. 3.

[3] Report of the Committee on Legal Aid and Advice in England and Wales (Cmd. 6641, 1945, par. 2).

For the purpose of the Act the Law Society established 12 Area and 112 Local Committees, and it is through these Area and Local Committees that the scheme is operated. Applications for legal aid are made to the secretary of the Local Committee, which has then to decide, subject to the right of appeal to the Area Committee, if the applicant has reasonable grounds for taking proceedings, and the terms on which a 'civil aid certificate' entitling him to legal aid will be granted.

Since the legal aid is only intended for those whose means are insufficient to enable them to engage solicitors and counsel and pay the necessary court costs themselves, and since even those who are assisted by the scheme are expected to contribute according to their means, applicants for legal aid must submit to an assessment of their resources by the National Assistance Board, which will decide on the amount of the contribution, if any, they should be asked to make. The benefits of the service are available for persons whose 'disposable income' that is, their income after allowances have been made for rent and rates (if these two items amount to a total of more than £39 a year or 15s. a week), income tax, maintenance of dependants and other necessary outgoings which the Board consider 'reasonable', is less than £420 a year, and whose disposable capital, that is capital excluding allowances for such items as house and furniture, is less than £500. Only persons with a disposable income of less than £156 per annum (£3 a week) or less than £75 disposable capital can receive legal aid entirely free of cost, other litigants will be expected to contribute up to half the excess of their income, and the whole of their disposable capital over this amount.[1] Hence litigation, even with legal aid, may still be quite costly in relation to the means of the applicant, and while this may be considered to be desirable in order to discourage vexatious and frivolous suits, the rather rigid limits imposed may mean that prosecuting a just and reasonable claim or defending a legal right will still involve considerable financial sacrifice for people of moderate means.

Since the establishment of the legal advice service envisaged by the Act has been postponed indefinitely, persons in need of such advice, but unable to afford the solicitor's fee, must still rely on whatever voluntary legal advice is available in their area. Many Citizens' Advice Bureaux can call on the services of a local solicitor who can be consulted by the workers and may even be willing on occasion to interview clients themselves. Such honorary solicitors

[1] Legal Aid and Advice Act, 1949, Part II, Sections 3 and 4. Legal Aid (Assessment of Resources) Regulations, 1950, S.I. 1950, No. 1358. The Law Society has issued a short explanatory leaflet for enquirers called *Can I get Legal Aid?* which sets out the conditions under which it is available.

often give valuable help, but any procedure by which the solicitor obtains his information second-hand is unsatisfactory, and may be dangerous, since, had he been able to question the client personally, material might have come to light which would have led him to take a different line.[1]

The position is more satisfactory in those towns and cities where there is a properly organised Poor Man's Lawyer Service, but these are few and far between. In 1939 less than a dozen provincial towns with a population of 100,000 or more had such a service, and the position has not materially changed since then, but where such an organisation exists its usefulness is demonstrated by the extensive use made of it. The range of enquiries brought to the Poor Man's Lawyer is wide, including disputes between landlord and tenant, accident compensation, matrimonial problems, hire-purchase difficulties, neighbours' quarrels and the like. Hence the solicitor giving advice must not only have an extensive knowledge of the law, but a sympathetic understanding of the outlook and social background of working-class people. Great credit is due to those solicitors who voluntarily undertake this arduous and sometimes thankless work in addition to their own professional duties.

Among the personal problems brought to case work agencies, Citizens' Advice Bureaux and Poor Man's Lawyer sessions, matrimonial difficulties occupy a prominent place, and statistics of divorce and judicial separations show that the number of marriage breakdowns is much greater than it was some years ago.[2] While this increase can be attributed in part to easier divorce, which the passing of the Matrimonial Causes Act, 1937, made possible, and in part to the hastier marriages and the disruptions of family life resulting from the Second World War, these do not in themselves account for the disturbingly large number of people who are today unable to settle down permanently with their marriage partners and create a happy and stable home for themselves and their children. Deeper reasons for this instability may perhaps be found in the disintegration of community life and the prevalent uncertainty about standards of personal conduct and relationships. These are problems of community living which require much careful thought, and unless adequate attention is paid to causation, remedial work with individual cases of marital discord is not likely to be very effective in reducing the number of marriage breakdowns. Nevertheless, consideration of long-term social trends, vital as this is, does not do away with the need for giving help and advice

[1] An example of this is given by R. E. Egerton, *Legal Aid.*

[2] In 1937 the number of divorce petition pleas was 5,750, by 1947 it had risen to 47,041. In 1952 the number of divorce cases was 33,770.

to unhappy men and women who are experiencing matrimonial and family difficulties.

In recent years a considerable amount of attention has been given to the possibility of co-ordinating and extending marriage guidance work, and new specialist agencies have come into being, which now supplement the patient unspectacular help which has been given for years past by clergymen, doctors, family case workers, probation officers and other social workers. The work of probation officers is especially important in this connection as one of their recognised duties is that of interviewing, with a view to their reconciliation, couples who apply to the magistrates' courts for separation orders, and, even where an immediate separation is not in question, they will advise and assist men and women who come to them with their matrimonial difficulties. It is generally recognised, however, that many people hesitate to approach officials who are associated in the public mind with the supervision of delinquents and the rather sordid atmosphere of the matrimonial courts. If couples are to seek advice before their difficulties become so acute that there is a real danger of breakdown centres away from the courts are needed.

Perhaps the best known of the recent attempts to meet this need and provide a specialised service for the prevention and treatment of marital difficulties is that of the National Marriage Guidance Council.[1] This is an independent voluntary organisation which bases its work on certain ethical principles to which those taking part are expected to adhere. Thus the Council emphasises the importance of the family as the basis of community life, and stresses that permanent monogamous marriage, outside of which sexual intercourse should not take place, is the right foundation for family life. It recognises that the achievement of a successful marriage is not an easy task, but one demanding 'sustained and disciplined effort', and considers that the community has 'a clear duty' to the rising generation to prepare them by 'instruction and guidance' for this task. Society should also seek to prevent 'the tragedy of the broken home' by providing 'sympathetic and expert treatment' for the prevention and cure of marital disharmony. Parenthood is regarded as the proper fulfilment of marriage, but scientific contraception is accepted as a means of assisting married couples to space their children. Its misuse 'to enable selfish and irresponsible people to escape the duties and disciplines of marriage and parenthood is condemned'. In thus sanctioning the use of contraceptives for certain purposes the Council differs from the Roman

[1] The work of this organisation is described by the founder, David Mace, in a book entitled *Marriage Counselling*, which was published in 1948.

Catholic Church, which has established its own Catholic Marriage Advisory Council.[1]

The work of the Marriage Guidance Council is twofold—educational and remedial. Educational work includes general preparatory instruction to young adults[2] and specific preparation and guidance to those definitely contemplating marriage. The Council itself attaches considerable importance to its educational activities, but public interest has centred rather in the 'remedial work' with couples in difficulties.[3] This is carried on in Marriage Guidance Centres which have been established by local effort in different parts of the country. Much of the work in such Centres is done by part-time 'counsellors' working on a voluntary basis. They give the initial interviews at which an attempt is made to diagnose the cause of the trouble, and decide whether it can be solved by friendly advice within the competence of the counsellor, or whether the skilled treatment of an expert is required. Such expert treatment is provided by 'consultants'—medical, psychiatric, ethical or legal—to whom the client can be referred if necessary. This set-up places a very heavy responsibility on the counsellors, as if they are well-intentioned but temperamentally unsuitable or imperfectly trained, they may do very considerable harm. The need for the careful selection and training of counsellors is recognised by the National Marriage Guidance Council which has evolved quite an elaborate technique for the purpose,[4] but there are still doubts in some quarters about the desirability of the extensive use of amateurs, even partially trained, for this type of work.

An entirely different approach from that of the Marriage Guidance Council is made to these problems by the Family Discussion Bureaux, set up by the Family Welfare Association in close co-operation with the Tavistock Institute of Human Relations and the Tavistock Clinic. The Bureaux appear to have originated as the result of discussions initiated by the Family Welfare Association, the objects of which were to discover whether families who were just beginning to experience difficulties in their personal relationships could be approached and if so in what way, and whether case workers could be trained to help people with this kind of problem. The question as to the possibility of research into

[1] The above paragraph is a summary of 'General Principles', set out in the Memorandum of the Work of the Marriage Guidance Council, published as Appendix A in Dr. Mace's book.

[2] The Council leaves sex-education in schools to other organisations.

[3] The Annual Report of the Marriage Guidance Council, 1950–1, states that in 1949 the seventy-one local Councils who sent in reports between them helped 6,651 married couples in difficulties, and prepared 1,097 engaged couples for marriage.

[4] Dr. D. Mace, op. cit., chs. xv and xvi.

patterns of family life in one or more London boroughs was also raised.[1] As a result of these discussions it was decided to launch a small experimental project whose aims should include the acquirement of knowledge and insight into problems of personal relationships, especially those centring round marriage and the family, the development of skills which would enable the case worker to deal with these problems, and the training of workers in the use of these skills. In the event two Bureaux were established, one in Fulham and one in Hendon, and it is from these two centres that the work is proceeding.

The Family Discussion Bureaux present an unusual and interesting combination of case work, preventive work by means of group discussions, training and research, all inextricably bound together. The case work and its related training are central, and although the number of cases handled so far is comparatively small the work is developing. It is based on psycho-analytic theory, and one of the questions to which an answer is sought is 'how far the theory of personality and inter-personal relations which can be derived from psycho-analytic work can... [provide]... a theoretical basis for workers attempting to understand and help clients with family problems, particularly those in which a disturbed relationship between husband and wife is the most prominent feature'.[2] Psycho-analytic theory determines the worker's approach to the case and the technique adopted in handling it, and the role of the worker is to help the client towards a better understanding of himself and his problems. 'Advice' or 'guidance' which would take away from him the responsibility of making his own decisions, and finding his own way to a better adjustment of his personal relationships, is regarded as inappropriate, and is replaced by a worker-client relationship through which the client gradually acquires sufficient insight into his problems to tackle them himself.

The two experiments in dealing with matrimonial difficulties just described have been made by voluntary organisations, but an interesting local authority experiment which sets out to tackle similar personal and family problems is the City of Manchester Family Welfare Service. The aim of this service is 'to bring advice and help to those people who are made unhappy by problems of

[1] Enid Eicholz, 'The Development of Family Discussion Bureaux Work', *Social Work*, Vol. VIII, No. 1, p. 496.

[2] A. T. M. Wilson, 'Current Problems in the Social Services', *Social Work*, Vol. VIII, No. 1, January 1951, p. 512. Dr. Wilson makes it clear that he considers that this does not exclude the possibility of other theories being used for this purpose, and suggests that many years of practical and experimental work will be needed before the type of theory most appropriate to different kinds of therapeutic work becomes clear.

personal relationships within the family'.[1] It was started on a voluntary basis, but after the implementation of the National Health Service Act was taken over by the Local Health Authority as a form of preventive mental health work, and it is now a municipal service.

The premises of two of the local maternity and child welfare centres have been made available for use by the service for consultations at certain times each week, and their use for this purpose has been found to be advantageous, as they are already identified in the public mind with services for the benefit of the family. The service is staffed by doctors trained in psychological medicine, who work on a part-time basis, a psychiatric social worker, and a receptionist-secretary. The treatment given is psychological 'and consists of helping individuals to set out their problems and come to terms with them',[2] but advice on practical matters such as budgeting is not excluded. Like the Family Discussion Bureaux the Manchester Family Welfare Service is still in the experimental stage but the indications are that it is making a real contribution to the maintenance of stable and happy family life.[3]

Public concern about the increase in the number of marriage breakdowns and interest in the possibilities of doing more to prevent them has led to the appointment in recent years of two government committees to study the question. Thus the Committee on Procedure in Matrimonial Causes, appointed in 1946,[4] included in its terms of reference consideration as to 'whether any (and if so what) machinery should be made available for the purpose of attempting a reconciliation between the parties, either before or after proceedings have been commenced'. After examining the work of the various agencies assisting in this, the Committee recommended that a Marriage Welfare Service was needed 'to afford help and guidance both in preparation for marriage and also in difficulties after marriage'. This service should not be a state institution, but the State should sponsor it. It should evolve gradually from the existing voluntary services experimenting in the field which should be grant-aided, since marriage guidance is a

[1] Nancy Lingard, 'Family Welfare Centres—A New Municipal Service', *Social Welfare*, Vol. VII, No. 9, April 1950, p. 211.

[2] Compare this approach with that of the Family Discussion Bureaux; in both cases it is psychological.

[3] In the first six months the clinic was opened 263 cases were dealt with, of which the largest number (109) were problems caused by 'disharmony' (including that caused by housing difficulties and cruelty), ibid.

[4] The final report was published in February 1947, H.M.S.O., Cmd. 7024. The Chairman of this Committee was Mr. Justice Denning and hence it is sometimes referred to as the Denning Committee.

form of social service of value to the State.[1] These recommendations were accepted by the government, and two years later the Home Secretary appointed a Departmental Committee, with Sir Sidney Harris as Chairman, to consider 'on what lines marriage guidance as a form of social service can be most advantageously developed in England and Wales if assisted by Exchequer grants, and to advise on what basis Exchequer grants can properly be made to this service'.[2] By this time the work of the National Marriage Guidance Council was fully established, and plans for the Family Discussion Bureaux well advanced. The Committee was sympathetic towards the objectives of the Marriage Guidance Council and considered that 'with the modest resources at its disposal, and within the limits of its comparatively short experience, the Council had endeavoured to build up a service on sensible and practical lines'.[3] Some concern was expressed about the quality and training of the lay counsellors and the Committee suggested that measures should be taken to set up a representative body of the three organisations mainly concerned with marriage guidance, namely the Marriage Guidance Council, the Catholic Marriage Advisory Council, and the F.W.A., to plan and supervise selection and training schemes. The Home Secretary would appoint the chairman and two other members of this body and the Ministers of Health and Education would also be represented on it. Given this co-operation the government could be expected to bear the cost of training at least for an experimental period of five years. Grants towards the headquarters expenses of the three organisations were also recommended, but it was suggested that local centres should approach their own local authorities for assistance. Developments along the lines recommended by these Reports are now taking place and the Marriage Guidance Training Board established by the Home Secretary on the lines suggested above began work in June 1949. Skilled advice in matrimonial and family difficulties, although far from universally obtainable, is slowly becoming more accessible to citizens in need of it.

The advisory or 'counselling' services described in this chapter differ considerably both in the range and type of problems handled and in their methods of dealing with them. They have this in common, however, that in all cases their object is to provide the informed advice or help appropriate to the specific problem brought to their notice by the person in difficulty. It is because the

[1] These recommendations are set out in the Final Report, pp. 12–13, pars. 28 and 29.

[2] Report of the Departmental Committee on grants for the Development of Marriage Guidance. Area 7566. H.M.S.O., November 1948.

[3] Op. cit., p. 9, par. 12.

staff of such an agency have, or are believed to have, specialised knowledge or professional skill, that it is approached, and however aintimte or personal the problcm handled, the worker-client relationship tends to be a rather more detached and professional one than in some forms of case work, for example, the intensive work with problem families described in the next chapter, in which there is a more intimate relationship, and the worker becomes much more of a family friend. In both approaches, however, respect for the client as a person should condition the workers' attitude, and enable him to develop the relationship constructively, so as best to serve the interests of the client.

CHAPTER IX

PROBLEM FAMILIES

THE mid-Victorian philanthropists who founded the Charity Organisation Society were, as we have seen, moved to take action not so much by the poverty of the people and their material deprivations, as by the moral and social degradation which so often accompanied it, particularly in the slums of the large cities. This they attempted to remedy by measures designed to restore individuals and families to self-respect and independence, hoping by a slow but sure process of personal reclamation to raise the standards of the people as a whole. Their ideals were high and their devotion great, but in general they made little impression on the vast mass of slum dwellers, and the next generation likened them to men standing on the edge of a morass in which their fellows were struggling and dying, and pulling out a victim here and a victim there, but making no attempt to drain the swamp. Twentieth-century reformers, reacting from the individualist policy and moralist outlook of their immediate predecessors, attributed the social evils which had so distressed the Victorians to environmental causes which could and should be remedied by social and economic planning. Thus they sought to raise the standards of the 'submerged tenth' by such measures as minimum wage legislation,[1] the provision of labour exchanges, social insurance, preventive health services and the like, and believed that when general social conditions were improved the worst features of slum life would disappear. Up to a point their hopes were realised, and on the eve of the last war public officials were able to compare the conditions of the people, and particularly of the children, with that at the beginning of the century, and with some justification congratulate themselves on the improvement. It was true that health visitors, sanitary inspectors, school attendance officers and other social and health workers were aware of the existence of families in the slum areas of the big towns, on the new housing estates, and even in the country villages, who remained sunk in squalor and apathy and

[1] General minimum wage legislation has never been introduced, but the Trade Boards Act of 1909 introduced the principle into certain 'sweated' industries.

untouched by the social progress around them. It was also true that ten years previously the Wood Committee, investigating the problem of mental deficiency,[1] had called attention to the existence within the community of a 'social problem' group containing a high proportion of mental defectives, paupers, criminals and other social undesirables, but the general public had no conception of the nature or extent of the evil, and, except perhaps in areas where there had been prolonged unemployment, was generally complacent about social conditions.

The evacuation shattered this complacency. For the first time middle- and working-class people living in country and suburb were brought into close contact with the slum dwellers from town and city, and learnt by direct experience, that the 'submerged tenth' still existed, 'like a hidden sore', 'poor, dirty and crude in its habits'.[2] More than this, the social changes brought about by the war and the rapid development of the social services which accompanied and followed it, helped to bring into the limelight the 'problem families'—families 'always on the edge of pauperism and crime, riddled with mental and physical defects, in and out of the courts for child neglect, a menace to the community of which the gravity is out of all proportion to their numbers',[3] as they were described by a group of investigators. Since then various attempts have been made to ascertain the numbers and distribution of such families, the reasons for their continued existence, and the best methods of dealing with the problem.[4]

One of the difficulties confronting the investigators into this social problem is that of defining the term 'problem family' sufficiently precisely. Problem families are easier to describe than to define, and a definition which will be really objective, and which will clearly demarcate such families from others of the same economic and social standing, is very difficult, if not impossible, to discover. This makes ascertainment of their numbers difficult, and one of the objects of the Pilot Inquiry recently undertaken in six

[1] See Chapter XIX, below.

[2] Women's Group on Public Welfare, *Our Towns, a Close Up*, Introduction, p. xiii. This is a study undertaken as a result of a resolution from the National Federation of Women's Institutes deploring certain conditions of English town life disclosed by evacuation, and asking that remedies should be sought.

[3] Ibid.

[4] Examples of such investigations are D. W. Savage, M.O.H., Herefordshire, 'Intelligence and Infant Mortality in Problem Families,' *British Medical Journal*, January 1946; R. C. Wofinden, Acting Deputy M.O.H., Rotherham, C.B., *Problem Families*, September 1944; T. Stephens, *Problem Families, an Experiment in Social Rehabilitation*, 1945; C. G. Tomlinson, Senior Administrative Officer, Public Health Department, Luton, *Families in Trouble*, 1946; Women's Group on Public Welfare, *The Neglected Child and His Family*, 1948; *Problem Families, Five Enquiries*, ed. C. P. Blacker and published by the Eugenics Society, 1952.

areas by the Problem Families Committee of the Eugenics Society is 'to standardise a serviceable procedure of investigation' for this purpose.[1]

A problem family always has multiple social, personal and financial problems, but not every family with a multiplicity of such problems is a problem family. It is their attitude towards their difficulties and towards those who would help them solve them which sets such families apart. 'Their peculiar characteristic', writes Tom Stephens in his study of sixty-two families in Liverpool and Manchester, 'is the inability to make the best of their circumstances and to profit by the facilities and services which are available for them',[2] and later in the same study he continues, 'The distinctive feature of the life of a family who have become a social problem is their passive acceptance of their conditions. Indeed with every kind of case . . . the collapse of morale and complete abandonment of any effort to recover is the key problem.'[3] This is confirmed by other writers on the subject, such as Professor A. C. Stevenson, who remarks, 'They are not merely disheartened, or have given up trying very hard; it just no longer occurs to them to visualise any improvement in their way of life',[4] and Dr. Stallybrass, formerly Deputy Medical Officer of Health for Liverpool, summed them up as 'Families presenting an abnormal amount of subnormal behaviour over long periods with a marked tendency to backsliding'.[5]

This complete collapse of morale manifests itself in the squalor and disorder in which a problem family lives.[6] Not only is the home unspeakably filthy and the children dirty, badly clad and unkempt, but there is no attempt to create an ordered pattern of living. Each member of the family follows his own whims, the children's school attendance is irregular and unpunctual, and the father is a bad time-keeper and frequently changes his job. The

[1] A report based on five of these enquiries has now been published. Blacker, op. cit.

[2] T. Stephens (ed.), *Problem Families*, 1945, p. 2.

[3] Ibid., p. 65.

[4] *Recent Advances in Social Medicine*, 1950, p. 143.

[5] Liverpool Council of Social Service, *Problem Families*. Report of a Conference convened on 26th January 1946, p. 7.

[6] 'Perhaps the most obvious common feature of these families is the disorder of their lives,' T. Stephens, op. cit. Compare this account from the Netherlands, 'There are no papers, no books, no clock or calendar or other things of rule and order. . . . There are no fixed places for storage. . . . There is an inability to do anything together, there is no tendency to help when meals must be prepared or to participate in a game. There is no fixed time for anything; rising, sleeping, eating happens individually, according to the whim of each'. A. Querido, 'The Problem Family in the Netherlands', *The Medical Officer*, Vol. LXXV, May 1946, p. 193.

prevalent irresponsibility and disorder shows itself too in the family's failure to manage its financial affairs—money is carelessly and recklessly spent when it is available, there is no attempt to budget or save, and so the family is usually in debt and unable to meet its regular commitments such as rent. There is, in fact, an all-round social inefficiency which defies every effort at improvement, and makes the problem family the despair of all types of health and social worker.

Just as it is difficult to give a rigid definition of a problem family, so it is difficult, if not impossible, to disentangle the factors which have combined to make them what they are. 'Each problem family presents a unique complex of circumstances, which can only be fully understood when regarded in its entirety',[1] and innate and environmental factors are inextricably blended though in different proportions in each case. Poverty is often present, but may be as much due to the inability of the father to hold down a steady job, or to the mismanagement of available resources by the mother, as to purely external causes. Similarly bad housing conditions are accentuated by neglect and incompetence, and the family's difficulty in obtaining a decent house is likely to be increased by their inability to produce a 'clean' rent-book. The mother's health is often poor, she may be worn out by child-bearing,—and this is an important contributory factor to the family's collapse in many cases—while poor marital relationships frequently embitter and complicate the situation.[2] Often the home is a 'broken' one, the father or mother having died or deserted the family. Underlying all environmental causes are defects of intelligence,[3] character and temperament, and it would seem to be these innate characteristics combined with a social heritage of generations of poverty, neglect and atrocious upbringing, which contribute most to the creation of a problem family, though poor health and misfortune often make matters worse.

As the causation of problem families is so complex it is not sur-

[1] T. Stephens, op. cit., p. 3.

[2] Dr. Wofinden in his survey of Rotherham found that in only about one-quarter of his problem families was there no evidence of irregular sexual relationships either in the form of parents cohabiting, or illegitimacy before or after marriage.

[3] Dr. Savage found that 110 out of the 393 'problem' mothers he tested were intellectually defective, ('Problem Families, Intelligence and Infant Mortality', *British Medical Journal*, 19th January 1946, p. 87), while in 50 out of the 243 problem families registered by Dr. Wofinden in Rotherham the mothers were either registered as mentally defective or appeared feeble-minded though not certified. Mr. Tomlinson considered that poor mental calibre was the sole discoverable factor in the family's condition in 48 out of his 251 cases, and 'an essential factor in combination with stress' in another 49 cases. *Families in Trouble*, p. 30.

prising that there is a good deal of difference in emphasis in the preventive and remedial measures advocated for dealing with them. To some sociologists the existence of such families is a manifestation of the disintegration of community life; to others they represent the failure of the educational and social services; others again consider them as proof of the need for a eugenic policy directed towards the elimination of mental abnormality and defect. Far more research is needed into these questions, and this issue is discussed later in the chapter. Meanwhile, however, measures to rehabilitate existing problem families wherever possible must go on, and in this task social workers may gain knowledge which will contribute towards a better understanding of the problem as a whole.

In spite of its limitations, and the disappointments which frequently occur, prolonged and intensive family case work has shown itself to be of value in dealing with problem families, particularly in those cases where the defects of character and intelligence are not too marked, and the family's failure is in large measure due to pressure of circumstances. Most family case work agencies have problem families on their books. They devote as much time and attention to them as can be spared by their chronically overworked staffs, and much good work has been done in this way. Their approach is particularly valuable as a family case worker considers the family and its problems as a whole, and this is essential as they are so closely interlocked. Of recent years a new case work agency, Family Service Units, has been established, which specialises in work with such families, and has started centres in London and other towns and cities. The service originated during the war, through the efforts of certain conscientious objectors who grouped themselves together to form the Pacifist Service Units, and who cared for unbilletable bombed-out families put in their charge during the raids on Merseyside. As time went on the Units realised that the family problems with which they were trying to cope were not wholly or even mainly due to the war, although they had been accentuated by it. The problems were deep-seated, and appeared to be permanent, but the Units believed that they could be tackled by the methods they had used with the unbilletable evacuees—methods based ultimately on religious and ethical principles. The Units thus began to experiment with the rehabilitation of families given up as hopeless by other social agencies. The work expanded and gradually won recognition, and it has now been put on a more permanent basis under the aegis of a formally constituted national organisation—the Family Service Units.

The approach of the Units to the families they are seeking to help, though fundamentally a case work approach, and with the

essentially case work aim of helping the family to become self-respecting and independent, differs in some respects from that of the more orthodox agencies. This is due in part to the nature of the problems with which the Units' workers are faced, and in part to their own preconceptions. Thus, whereas in most case work situations the client approaches the agency because he is conscious of needing the help it has to offer, problem families are not conscious of their failure, and do not apply to the Units themselves, instead they are referred by other bodies who consider that intensive work is needed. Hence the offer of help comes from the Units to the family. The worker takes the initiative and determines the amount and type of assistance required, but his position is unauthoritarian and unofficial and the family can ask him to withdraw at any time.[1] Further, while the basis of most types of case work is the spoken word, interview between client and worker has little or no effect on the problem family. Instead the Units rely on friendship expressed in action to work the miracle and bring the family's dead or dying self-respect to life. The worker goes to the family prepared, if necessary, to clean and distemper, scrub dirty floors, cleanse filthy bedding, wash and toothcomb verminous and obstreperous children, and generally assist the family in every possible way, hoping thus to earn their confidence and give them a new outlook on life. Material help, such as clothes, furniture or bedding, will also be provided if needs be, often with the co-operation of another agency, since the resources of the Units are limited. Manual work and material help are, however, regarded as useless if the worker cannot utilise them as means of social rehabilitation. Hence in the long run it is the worker's personality that counts, and 'ultimately it is on the interplay of personality, and on the ability of the worker to give from his own spiritual resources that the value of the work will depend'.[2]

The original Pacifist Service Units members who undertook this work with problem families were, in the main, young and enthusiastic amateurs. They made mistakes, and did not always entirely avoid the dangers of sentimentality and over-identification with the families helped to which their ideals and methods rendered them particularly liable. Moreover, continuous intensive work over long periods with problem families, as with any other sub-

[1] *Family Service Units, an Experiment in Social Rehabilitation*—pamphlet issued by Family Service Units, p. 9.

In Chapter VII the case worker was given the feminine gender as by tradition most case work is done by women. The F.S.U. worker is, however, just as, if not more, likely to be a man, and so the masculine gender is substituted throughout this description of their work.

[2] T. Stephens, op. cit., p. 66.

normal or deviant group, may result in a loss of sense of proportion, or an insensible lowering of standards. Thus there is a good deal of force in the argument put forward by some social workers that the type of work carried out by the Family Service Units would be better done as part of the work of a case work agency which deals with normal families in trouble as well as problem families. At the same time it is doubtful if the rather unorthodox, but undoubtedly sometimes effective, methods of the Units could have been tried out within the framework of an existing case work organisation. Even voluntary organisations tend to become stereotyped in their methods and to regard the ideas of the enthusiastic newcomer in the field with a measure of scepticism. Nevertheless, the enthusiast, for all his blundering, may find a new and hopeful way of tackling an old problem, and to a certain extent this appears to have happened here. The danger is, that in social work, the materials used in the experiment are human beings, and it is this which makes the trained and experienced worker so fearful of the possible consequences of the intrusion of outsiders. By now the Units themselves have become much more highly organised, with national and local committees and a developing tradition of their own, and are becoming more widely accepted as a recognised social service organisation.

Although the work of the Family Service Units has attracted a good deal of attention it is not possible as yet to assess the success and limitations of their methods, the extent to which they can be applied, and their influence on the theory and practice of case work as a whole. Tom Stephens, in his description of the Units' work from which several quotations have already been made, estimated that out of sixty-two families visited by them for a minimum period of six months 'barely more than one-tenth' responded by a substantial improvement in standards, and these were families where there was a reasonable level of intelligence, and a basis of affection on which it was possible to build. It should be remembered, however, that up to that time, the Units' cases were, in the main, families abandoned as hopeless by other agencies. Further, while only one in ten of the families helped made a substantial improvement, a considerably larger number were helped to maintain a minimum standard somewhat higher than they would otherwise have done, and in some cases a complete family breakdown and the removal of the children to institutional care was prevented. In these cases, however, constant supervision was necessary to prevent back-sliding, and it is doubtful if any real change in the family's attitude had been or could be achieved. There were, moreover, a small proportion of cases where 'inherent mental and psychological defects in the parents present an unassailable prob-

lem to the home visitor',[1] and it was clear that more drastic methods of dealing with the situation were needed.

Although parents may be prosecuted for neglecting their children, and children may, in extreme cases, be removed from their care,[2] there are in this country no powers of compulsory supervision or control over the family as a whole. Experiments involving a measure of compulsion have been tried in other parts of the world however. Perhaps the best known of these are the ones carried out in the Netherlands, at the Hague, Utrecht and Amsterdam.[3] In all these cities the problem was first brought to the notice of the authorities as a housing one—as in the housing shortage after the First World War the families were left homeless because they were so undesirable that no property owner would rent them a house. In order to deal with this situation a proposal was made that the authorities should erect 'dwelling schools', or special blocks of dwellings for undesirable families where they would be given opportunities to 'learn to use a home and fulfil their obligations towards the owner and their neighbours'.[4] Thus in the 'Village' at Amsterdam—a specially built street of fifty-two houses situated on a narrow peninsula between two canals—the families received various forms of social assistance, including a kindergarten, washhouse, regular medical inspection of the infants, and advice to the women in the running of their households. Both here and at Utrecht there was a measure of supervision, which in Amsterdam was exercised by a woman housing manager. While the Utrecht experiment appears to have resulted in some improvement in health and hygiene,[5] Dr. Querido, Director of the Department of Mental Hygiene, writes of Amsterdam, 'there could be no question that as a dwelling school the plan was an utter failure'. Instead of an educational institution fitting the families placed there for life in the normal community 'the compound has become nothing but a permanent provision for undesirable families' and when they were finally dispersed 'they lived in almost indescribable squalor in the poorest quarters of the town'. It was clear that the approach had been too narrow and superficial, and the problem was one which could not be adequately dealt with by housing

[1] Op. cit., p. 29.

[2] These measures are discussed in connection with the specific question of child neglect in Chapter XIII, below.

[3] For more detailed descriptions than it is possible to give here see A. Querido, op. cit.; and Women's Group on Public Welfare, *The Neglected Child and His Family*, pp. 100–2.

[4] The quotations in this and the succeeding paragraph are from Dr. Querido's article already cited unless otherwise stated.

[5] According to a Report on Controlled Houses quoted in *The Neglected Child and His Family*, p. 102.

policies, however enlightened, even if compulsory powers were invoked to secure the good behaviour of the tenants. More fundamental diagnosis and treatment were required.

Dr. Querido, who was brought in at this stage, originally regarded the problem as one of mental health, but as a result of his study of the families in the Village finally arrived at the conception of the problem family as 'a diseased biological unit, social deterioration being its chief symptom'. Its treatment required the psychotherapy of the family as a whole, and after the Second World War, during which period the problem became more acute, proposals were made to provide the means for such treatment and the power to make these means effective. These proposals, if they become law, will give the court power to place 'socially deteriorated' families who have failed to respond to voluntary supervision under guardianship, and if this fails to bring about the rehabilitation of the family it may be placed in an observation camp for six months. At the expiration of this period it may either be given another chance to adapt itself to life in the normal community, or sent to an education camp for a further period.

These measures involve drastic interference with the family's liberty and way of life, and hence it is necessary to define very carefully the type of family which is to be subject to them. A family can only be placed under the guardianship of the courts if its social deterioration is demonstrated in that it lives on sources of income such as crime or prostitution which cannot be tolerated, that it does not make use of its natural potentialities and as a consequence lives on public or private subsidies, and that it is a danger to the community by reason of child neglect, recalcitrant behaviour, dirt, etc., all in a serious and continuous degree.[1] Before assuming guardianship the court must also be satisfied that it is unlikely that the family's condition can be improved without such action.

Camps similar to those envisaged in the legislation now being considered are already in existence, and families who have consented 'voluntarily' to submit to observation and treatment are living there. In the view of those sponsoring the scheme the results of these experimental measures are sufficiently encouraging for the authorities to go forward and adopt wide compulsory powers.

The new camps as envisaged will be small, accommodating not

[1] Such a measure can never be imposed as the result of unemployment or poverty as such, there must be failure as well as misfortune. The information in this and the succeeding paragraph was given me in a letter from Dr. Querido, which he has kindly given me permission to quote.

more than sixteen families and will be 'richly differentiated'. Since the object of the experiment is the final re-establishment of the family in society, complete segregation will be avoided, and while the family is living in an 'education camp' the children will go to school and the men be encouraged to find work in the neighbourhood. This accentuates the fact that residence in a camp is only part of the whole process of rehabilitation, the most important part of which may well be guidance in living in society.

The Dutch plans for the control and treatment of problem families are very far-reaching, and involve considerable interference with the liberty of the subject. The strong element of compulsion may make them distasteful to many English social workers, who will probably consider that restrictions of this type are likely to hinder rather than to foster the growth of personal responsibility. The Women's Group on Public Welfare puts the case against such compulsory schemes forcibly: 'Even accepting the existence of this intransigent group and appreciating that special measures must be taken for such problems,' they write, 'we are not in favour of any form of compulsory segregation or system whereby families are registered under special powers for the following reasons: partly because since co-operation is the essence of successful rehabilitation, we are doubtful whether such results as would be obtained by compulsion would be worth the cost in the loss of human dignity and independence; partly because it is almost impossible to draw the line between "problem" and "near problem"; but chiefly because we dislike the idea of labelling any section of the community to its detriment. . . . To segregate the failures in society is in our view an indignity which no advantage of hygiene and progress can outweigh.'[1]

The arguments of the Women's Group on Public Welfare are sound, but if we reject measures based on compulsion we are left with the responsibility of finding equally effective means of dealing with the problem. The Dutch experiments have at least shown an awareness of the seriousness of the evil and willingness to take active measures to eradicate it. In this country the present tendency among administrators appears to be to concentrate on the more specific problem of child neglect, which is often found as one of the elements in a problem family situation although sometimes dissociated from it, rather than to attempt to tackle the more general problem.[2] It is significant, however, that in a recent government circular, *Children Neglected or Ill-treated in their Own*

[1] *The Neglected Child and His Family*, pp. 106–7.

[2] The measures taken and proposed to deal with child neglect are described in Chapter XIII.

Homes,[1] reference is made to obtaining the co-operation of the various local services to 'meet the needs of the family as a whole'. This is an advance, but will not take us very far until we have a much clearer idea than we have at present as to what the real needs of these families are, and this will not be discovered without much more research than there has been to date.

Research along two lines would seem to be required. First, there is the need for further investigation along the lines which have been already cited into the problem families themselves—their incidence, distribution, characteristics and causation. Such investigations of these social casualties are insufficient in themselves, however. If, as Dr. Querido suggests, problem families are diseased biological units, the biological unit being a family, and social deterioration the main symptom of the disease, then in order to understand the condition it is important to study not only families in the last stages of deterioration, but families which are healthy, and in particular those which are showing signs of strain. Only in this way will the factors which predispose a family to social disintegration be better understood. The approach of the Family Discussion Bureaux 'from health to sickness' would seem to be applicable here, and such an approach would also throw light on such vexed issues as the relationship between problem family conditions and mental defect and illness, and the question as to the extent to which problem families form a static 'social problem group' persisting from generation to generation.[2] Fundamental research of the extent and kind needed would be expensive, and its effects might not be immediately obvious, but if it led to effective preventive measures its value would be great, not only to the individual families concerned but to the community as a whole. Problem families are a continual drain on the social services, for all that they seem to profit so little from them; they have a degrading influence on those with whom they are in contact and the neighbourhood in which they live, and their presence in our midst lowers the whole standard of community life. The palliative measures we are using now to deal with the situation are expensive in terms of both money and man-power, and in spite of the idealism and devotion of the workers can do little more in many cases than

[1] Circular 157/50, Home Office, 78/50, Ministry of Health, 225/80, Ministry of Education, July 1950. The provisions of the Circular are outlined in Chapter XIII.

[2] Mr. Tomlinson has some interesting observations to make on this point as a result of his survey of Luton. He finds that 'there is not sufficient evidence to prove the existence of a static social problem group in Luton', but suggests that such groups may exist in 'such old and densely populated areas as London and South Lancashire which have been reservoirs of human wreckage for many generations'. *Families in Trouble*, p. 37.

hold the family together at a slightly higher level than it would otherwise have reached, while the break-up of the family by removing and making alternative provision for the children, in any case an admission of failure, is more expensive still. We are still groping with this problem, and our attempts at treatment are rendered largely ineffective by our lack of knowledge. Hence, research and experiment of all kinds are needed and should be encouraged in every possible way.

PART THREE

SOCIAL SERVICES FOR CHILDREN AND YOUNG PEOPLE

'By the present Declaration of the Rights of the Child, commonly known as the Declaration of Geneva, men and women of all nations, recognising that mankind owes to the child the best that it has to give, declare and accept it as their duty that beyond and above all considerations of race nationality or creed:

1. The child must be given the means requisite for its normal development, both materially and spiritually.

2. The child that is hungry must be fed; the child that is sick must be nursed; the child that is backward must be helped; the delinquent child must be reclaimed; and the orphan and waif must be sheltered and succoured;

3. The child must be the first to receive relief in times of distress;

4. The child must be put in a position to earn a livelihood and must be protected against every form of exploitation.

5 The child must be brought up in the consciousness that its talents must be devoted to the service of its fellow men.'—*Declaration of the Rights of the Child*, adopted by the Assembly of the League of Nations in 1924.

CHAPTER X

THE WELFARE OF MOTHERS AND YOUNG CHILDREN

A WIDE variety of welfare services, both public and voluntary, exists to meet the needs of children. Their development was fostered partly by the pity aroused in most people by the suffering of the innocent and helpless, and partly by a desire to improve the future health and fitness of the nation. In recent years this latter incentive has been reinforced by the anxiety caused by the decline in the birth-rate. For many years before this last war children were becoming scarcer, and as they became scarcer they became more precious, and the greater the efforts which were made to ensure that those that were born received the best possible care, so that they might survive and grow into healthy and well-adjusted men and women, able to make their maximum contribution to the nation. Moreover, it is now realised that since parenthood is becoming to a large and increasing extent voluntary, it must be made attractive, and the nation as a whole take over a large measure of responsibility for the maintenance and upbringing of children, so that parents of large families do not suffer serious economic and social disadvantages compared with the single and childless.[1]

All these considerations have helped to bring about the modern developments in child welfare, but there has been little long-term planning based on a considered policy.[2] Like other social services the child welfare services have grown up piecemeal, partly as the result of the pioneer efforts of individuals, such as Dr. Barnardo or Margaret Beavan of Liverpool, who left behind them vigorous voluntary organisations to carry on their work; partly owing to the initiative of local Medical Officers of Health, such as Dr. Drew Harris of St. Helens who, as already mentioned, started the first milk depot in this country in 1899; and partly to the efforts of such

[1] This point is made by the Royal Commission on Population. See particularly Chapters V and XIV.

[2] A plea for a comprehensive family welfare policy based on these considerations is made by the Swedish sociologist, Alva Myrdal, *Nation and Family*, 1945.

enlightened civil servants as Sir James Kay-Shuttleworth,[1] Sir Arthur Newsholme,[2] and Sir George Newman.[3]

A further complicating factor in the development of social services for children has been that, while a policy of providing social services for their benefit has been generally accepted, it has not been without serious misgivings in some quarters, for there were, and still are, those who fear lest such services destroy family responsibility and the underlying values of family life. These fears were strongly expressed during the early years of the century, when the advocates of school feeding and the school medical service had to fight not only apathy and ignorance, but the serious and informed criticism of those who believed so strongly in the importance of maintaining the unity and independence of the family, that they argued that it might be better for a child to remain hungry than for it to be fed in such a way as to destroy the parents' sense of responsibility for its welfare.[4] Similar fears still influence the attitude of some people towards nursery schools and family allowances. In the long run there should be no real conflict between higher standards of community care for children and the maintenence of all that is best in family life. Indeed, the one should strengthen the other, and this has been achieved in certain instances, notably, for example, in the maternity and child welfare services which have done much to raise the standard of child care. Perhaps the secret of the success of this group of services lies in the fact that they do not take any responsibility for the care of her child from the mother. Instead she is helped through the services of trained yet sympathetic and understanding people to raise her standards of child care, and acquire the skill and knowledge which will enable her to come nearer to reaching them.[5]

Apart from the provision of formal education, which, while a form of social service in the broad sense of the term, has a distinctive outlook, and many opportunities and problems outside the field of social work, and cannot be dealt with in detail here, the social services for children may be divided into two groups. One is primarily concerned with promoting the general well-being of all children and with helping those handicapped by defect, disease, deformity or maladjustment, and the other aims at ensuring that no child shall be neglected or cruelly treated, and seeks to provide

[1] First Secretary of the Committee of Council on Education, 1839–49.

[2] Medical Officer of Health to the Local Government Board, 1908–19.

[3] Chief Medical Officer to the Board of Education from the inception of the School Medical Service until his retirement in 1935. From 1919 onwards he combined this with the post of Chief Medical Officer to the Ministry of Health.

[4] F. Le Gros Clarke, *The Social History of the School Meals Service*, p. 7.

[5] The effects of the development of the social services on the family are discussed further in Chapter XXII.

substitute homes for the destitute and unwanted and others deprived of home care. The first group of services forms the subject of this chapter and two which follow; the second group is dealt with in Chapter XIII, but there is some unavoidable overlapping, especially in the latter part of this chapter.

The maternity and child welfare services which are the subject of this chapter, form part of the National Health Service. They are concerned to promote the health of both mother and child so that the mother gives birth to her child with the minimum amount of danger and discomfort, and without serious after-effects on her own health, while the child is born healthy and receives adequate care until he starts school. The administration of these services has already been described in Chapter V. They provide for the ante-natal and post-natal supervision of the mother, including dental care; skilled attention at the time of the child's birth; and supervision of the health of the infant. With these medical services are associated measures to ensure that both expectant and nursing mothers and their children have opportunities of procuring the food supplements particularly beneficial to them, while education in the care of children is an important side of the work. This educational work is carried on by lectures, demonstrations and individual advice given at the clinics, and by the health visitors who visit the mothers in their homes and help and guide them in the management and care of their children.

The National Health Service Act[1] makes the provision of such services by the Local Health Authorities obligatory, but there is no corresponding obligation on the mothers to make use of them. However, they are now widely used by all classes of the community. This is shown by a survey made by the Joint Committee of the Royal College of Obstetricians and Gynaecologists and the Population Investigation Committee in 1946. Out of a sample of 13,687 mothers drawn from 424 local authority areas in England, Wales and Scotland, only 0·9 per cent received no ante-natal supervision at all; 72·9 per cent were supervised by local authority services, either at clinics, through general practitioner services (mainly in Scotland) or by midwives; while 26·2 per cent made private arrangements for supervision.[2] The survey revealed, however, that a large number of women did not put themselves under supervision sufficiently early in pregnancy, many postponing it until the last three months, when it is too late for ante-natal care to be really beneficial, while in some areas accommodation was inadequate, and a visit to a clinic meant a long journey followed by a

[1] Sections 22, 23 and 24.

[2] It should be noted that this survey was made before the National Health Service Act was implemented.

longer wait in dreary and uncomfortable surroundings, all for the sake of a hasty examination.[1] This last difficulty was attributed in part to shortages of staff, which, the survey suggested, might be minimised by a greater use of midwives or health visitors for routine examinations, the doctor confining his attention to special cases. As we have already seen[2] there has been some falling-off in the attendances at ante-natal clinics since the National Health Service Act has made it possible for women to be given medical examinations by their own doctors free of charge, and from the educational point of view this is unfortunate.

On the whole, good use is made of infant welfare centres, but in spite of the efforts made to maintain some supervision over toddlers, very few children are brought to the clinics after the age of eighteen months.[3] Hence, except for the fortunate few who attend nursery schools, there is a gap in health supervision at a very important stage in the young child's life, and many ailments and deformities detected by the school doctor at his first examination could be prevented or checked at an early stage if the child had adequate health care throughout these critical years.

Despite these criticisms, the maternity and child welfare services can claim to be amongst the most successful of the social services, if their success be judged by the improved standards of physical health. But there are still gaps to be filled in and improvements to be made. There must be closer co-operation between the different branches of the service, especially as the National Health Service Act, instead of creating a unified service, has perpetuated and even accentuated the already existing administrative divisions, and this has already been stressed.[4] There is room, too, for the levelling up of the standards of the less-advanced areas to those of the more advanced, and in one of its recent reports the Ministry of Health suggests that careful studies of the organisation of the services, such as that carried out by a medical officer of the Ministry in 1947 in a particular County Borough where the infant mortality rates were high, might be beneficial in other areas.[5]

A more fundamental criticism of the maternity and child welfare services is that of Dr. James Halliday who believes that the modern stress on physical hygiene, for which he considers the maternity and child welfare services in part responsible, has resulted in over-rigid training and rather impersonal treatment of young infants, which is likely to have harmful psychological and

[1] Op. cit., ch. iv. An example is given of a clinic where on the day of the survey visit the doctor had examined twenty-nine women in eighty minutes.
[2] Chapter V. [3] *Maternity Survey*, ch. vii. [4] Chapter V.
[5] Report of the Ministry of Health for the year ended 31st March 1948, Cmd. 7734, p. 106.

psychosomatic effects.[1] Not everyone would go all the way with Dr. Halliday, but the vital importance of meeting the emotional as well as the physical needs of the child is now widely recognised, and more attention is being paid to them. Further, it is becoming clear that the maternity and child welfare services could and should play a major part in helping mothers to understand and meet these needs, and in detecting and checking early symptoms of maladjustment. This can only be achieved, however, if medical officers and health visitors have adequate training in child psychology, as well as in the physical care of the child,[2] and there are ample opportunities for co-operation with the child guidance and other psychological services.[3]

The maternity and child welfare services just described are concerned mainly with the general health of mothers and young children, but there are two groups of mothers and children for whom more intensive social care is needed, namely the working mother and her child and the unmarried mother and her child.

The number of women with young children who work outside their homes for gain is not known precisely. The Survey of the Royal College of Obstetricians and Gynaecologists mentioned above revealed that almost 75 per cent of the unmarried women in the survey sample were in full-time employment during pregnancy, compared with 28 per cent of the married women, while this latter figure masked a striking difference between the married primigravidae, 59·3 per cent of whom were working, and the multigravidae, only 8·7 per cent of whom were workers. The survey points out, however, that the year 1945–6, which was the year covered, was the period of transition from war to peace, and in some respects social and economic circumstances were abnormal, so these proportions cannot be regarded as necessarily typical of the post-war years.

Before the war women normally gave up outside employment on marriage, except in certain occupations and areas, for example, among the cotton weavers of Lancashire and the jute workers of Dundee, but during the war the need for women workers in the factories became acute, and although mothers with young children were never directed into industry, they were encouraged to undertake full- or part-time work if at all possible, and special provisions were made to encourage them to do so. Many people hoped that the end of the war would see a reversal of this policy, but con-

[1] J. L. Halliday, M.D., D.P.H., *Psycho-social Medicine, a Study of the Sick Society*, pp. 120 ff.

[2] The training of health visitors is the subject of much discussion at present, the object being to improve their social skill and awareness without sacrificing the groundwork of hygiene and child-care.

[3] Some experiments along these lines have already been made. This question is raised again in Chapter XII in connection with the future of child guidance.

tinuing economic crises have maintained the demand for women's work, particularly in certain industries, and some women choose to continue in work, even at some cost to themselves and their children, rather than sacrifice the higher standard of life to which they have become accustomed. There are also those women, mainly highly trained women of the professional class, who feel dissatisfied and frustrated if they have to give up their work to devote themselves to household duties and the care of children.

The main health and social problems arising from the employment of child-bearing women are, first, the effect of outside employment on the health of the pregnant woman, including the question of adequate supervision; secondly, income maintenance for a sufficiently long period before and after confinement for those who are dependent on their earnings; and thirdly, provision for the care of the child.

There has been a good deal of discussion as to the effect of work outside the home on the health of the expectant mother, the risk of her death in childbirth, and the possibility of her having a miscarriage or stillbirth. An investigation into maternal mortality made by the Ministry of Health in 1937 revealed that for a variety of areas the proportion of women employed in any gainful occupation and the rates of puerperal mortality tended to rise and fall together, although there were many exceptions to this rule, and this tendency was somewhat emphasised when the women were employed in industry.[1] The Survey Committee of the Royal College of Obstetricians and Gynaecologists found that while there was no significant difference between the stillbirth and premature birth-rate of workers and non-workers, if such work was confined to the first five months of pregnancy, later working increased the risk of stillbirth to some extent and greatly increased the risk of prematurity.[2] The general opinion appears to be that, with the possible exception of weaving, which would seem to carry a specially heavy risk, work outside the home during pregnancy is not in itself harmful, provided it is reasonably light, is carried on under good conditions, does not preclude the possibility of adequate medical supervision,[3] and is given up in good time. What *is* likely

[1] Ministry of Health Report on an Investigation into Maternal Mortality, Cmd. 5422/37, pp. 73–74 and p. 279

[2] Op. cit., p. 168. The findings of the Survey Committee showed a stillbirth rate of 30·7 per 1,000 in those cases in which the mother left work less than five months before delivery, 24·2 per 1,000 in those cases in which she left work earlier; 11·3 per cent of the babies of the former group of women weighed less than 5½ lb. at birth, 8·1 per cent of those of the latter group.

[3] Ideally this should include supervision at the place of work by a doctor who knows the conditions prevailing there, but this is only possible in factories employing large numbers of women workers. Attention should be given to this if ever an industrial health service is planned, cf. P.E.P., *Planning*, No. 254, 23rd August 1946—'Mothers in Jobs', pp. 7 and 10.

to be harmful to the pregnant woman, however, is the double burden of tiring industrial work and onerous household duties. Together these may easily impose an excessive strain.

It has already been pointed out that whether or not industrial work has a harmful effect depends to a large extent on the length of time it is continued. When times were bad, and there was no provision for income maintenance during absence from work, women whose contribution to the family income was essential if basic needs were to be met, were tempted to remain at work until very near their confinement. The findings of the Maternity Survey indicate that it is unusual for a woman to do this to-day. The average date of cessation of work in their sample was twenty-two weeks before delivery, and only 12·5 per cent of the women continued at work until the last ten weeks.[1] The introduction of the maternity allowance as part of the maternity benefit under the National Insurance Act[2] has eased the economic position of the gainfully occupied woman, since she is now entitled to a weekly allowance of 40s. for 18 weeks beginning the eleventh week before the expected date of the confinement. Moreover, full employment and the higher wages earned by both men and women have reduced the extent of the family's dependence on the wife's earnings, and these two factors taken together make it more possible for a married woman to give up work in reasonable time without serious hardship. Both the Public Health Act, 1936, and the Factories Act, 1937, prohibit the employment of a woman in a factory or workshop within four weeks after giving birth to a child, but in any case it appears to be unusual for a woman to return so soon. Only 6 per cent of the women workers who were mothers of first children, and 3 per cent of the mothers of second or subsequent children, visited two months after their confinement in connection with the Maternity Survey, had either returned to work or were proposing to do so in the near future.[3]

The unsatisfactory nature of the care given to the child of the woman worker was one of the first evils of the factory system to engage the attention of the social reformers of the first half of the nineteenth century. Investigations revealed that the infant whose mother worked in a factory was usually 'minded' by an old woman or young child, and was kept quiet by frequent doses of mixtures

[1] Cf. figures given by L. B. Browne and J. V. Sullivan quoted by P.E.P., op. cit. Out of a sample of ninety pregnant women working in a large factory, sixty had given up work before the end of the twenty-eighth week, seven remained in work till the thirty-sixth week.

[2] Described in detail in Chapter III, above.

[3] Similarly, only eighteen of the eighty-three women who could be traced by L. B. Browne, and J. V. Sullivan within seventeen months after confinement had returned to work.

containing opium or laudanum.[1] Rising standards of child care, shorter working hours and other improvements gradually brought the worst abuses of daily minding to an end, but the practice itself persisted in those parts of the country where married women's work remained an accepted part of the social pattern, and it still prevails in these areas. The minder is usually a relative (frequently she is Granny), or a neighbour, who receives a small weekly payment for her trouble. Her standards may or may not be as high as those of the mother who confides the child to her care, but even if they are, the child may suffer as the result of differences of handling, and of the partial separation from his mother.

The alternative to the 'minder' is the day nursery. These were started on a voluntary basis in the nineteenth century, but since the passing of the Maternity and Child Welfare Act, 1918, local authorities have had powers to provide them, and grant aid has been given by the Ministry of Health. On the eve of the recent war 104 municipal and voluntary nurseries accommodating 3,700 children were in receipt of grant aid. During the early months of the war a number of residential nurseries were provided in reception areas, but the main drive for increased day nursery accommodation came in 1941, and was occasioned by the need to attract as many women as possible into industry. Special efforts, involving the co-operation of local Maternity and Child Welfare Committees and Local Education Authorities with the Ministries of Health and Labour, but financed entirely from Central Government funds, were made to establish nurseries in those parts of the country where the demand for women's work was great, and the War-time Nursery, staffed with the help of the Child Care Reserve, became an established social service.

With the end of hostilities the need for day nurseries declined somewhat, but it still remained, and in 1946 the war-time service merged into a peace-time service. The major responsibility for the provision of day nurseries in a particular area now rests with the Local Health Authority, but the Report of the Ministry of Health for the year 1946–7 notes the increase during the year in the num-

[1] For example, the evidence of a druggist from a poor district of Manchester as reported in the Second Report of the Commissioners of Inquiry into the State of Large Towns and Populous Districts, 1845: 'There is scarcely a single family of the really poorer classes in which this custom does not prevail. The mother goes out to her work in the morning leaving her child in charge either of a woman who cannot be troubled with it, or with another child of perhaps ten years old. A dose of "quietness" is given. . . . The child thus drugged sleeps and may waken at dinner-time . . . when . . . the child receives another dose. Well, the father and mother come home at night quite fatigued . . . they must have sleep undisturbed by the child, so it is again drugged, and in this manner young children are often drugged three times in each day.'

ber of nurseries provided by industrial undertakings. These have the advantages that the mother has only one journey morning and evening, and is not as completely cut off from her child during the day; but they can only be maintained by firms employing large numbers of women, and the local authority must continue to cater for the women who work in small or medium-sized factories, or who are employed in other ways. At the end of 1953 there were 712 full-time day nurseries maintained by local authorities and 121 factory nurseries.[1]

The Ministry of Health has the overall responsibility of ensuring that the care given to young children whose mothers go out to work reaches a satisfactory standard, whether these children are placed in a local authority nursery, or in one run by a voluntary association or private individual, or are cared for by daily minders. The Nurseries and Child Minders Regulation Act, passed in 1948, seeks to ensure this by providing that all day and short-term residential nurseries and persons other than relatives who receive more than two children under the age of five from different households for reward, either for a substantial part of any one day or for periods not exceeding six days,[2] shall be registered with the Local Health Authority, which is given powers to inspect the nursery or other premises where the children are kept, limit the numbers of children received, and insist that proper standards are maintained. If it is not satisfied, the Authority may, subject to the right of appeal by the occupier to a Court of Summary Jurisdiction, cancel the registration. Unfortunately the Act does not give complete protection to children whose mothers leave them in the care of others, since it does not include minders taking children singly, nor those who are relatives of the working mother, and there is, too, the administrative difficulty of ensuring that its provisions are known and enforced. Moreover, no special community provisions are made for the school child who, unless there is a play centre in the neighbourhood, or a relative or neighbour to take him in, has to fill in the time between the closing of the school and his mother's return from work either in the streets or in the empty house. The numbers of such children may not be large, but their position is unsatisfactory, as must be that of any child whose mother leaves him for the greater part of the day.

There are a minority of women, particularly among the pro-

[1] Report of the Ministry of Health for the year ended 31st December 1953, pt. I, pp. 122 and 124. Cmd. 9321.

[2] Persons receiving children for long periods come within the scope of the Child Life Protection Provisions of the Children Act. Nursery Schools in respect of which payments are made by the Ministry of Education are also exempted from the provisions of this Act as they are subject to inspection by this Ministry; children's homes and hospitals are also exempt (Section 8).

fessional classes, who find domestic work and child care distasteful or unsatisfying, and in a free society these cannot be compelled to devote their whole time to it against their own inclinations, but probably the majority of women with young children who go out to work are driven by economic need, or enticed by the thought of the higher standard of living which a double wage will make possible. In the interest of the child wage rates for heads of households and provisions such as family allowances, widowed mothers' pensions and National Assistance should be such as to reduce the numbers of mothers compelled to earn to provide for themselves and their children to the minimum, and economic considerations should not be allowed to predominate over social ones to the extent of giving general encouragement to mothers to enter or remain in industrial work if this is to the detriment of their children. There will always be some working mothers however, and hence adequate community provision and legal safeguards for their care and that of their children are essential, and the facilities outlined above should be extended and improved until these needs are fully met.[1]

The health and social problems of the married woman worker with young children are usually relatively simple compared with those of the unmarried woman who is expecting to become a mother. The nature and complexity of the difficulties to be overcome, and the responsibilities to be met by these women vary considerably, and are dependent on a number of factors, one of the most important of which is the nature of the liaison with the putative father of the child. Thus, there are many cases in which their liaison is permanent, or relatively so, but marriage may not be possible.[2] Many of these couples are highly respectable persons with good social standards. They live as though they were married and give their children a stable background and good upbringing according to their lights, so that no special social care appears to be required, but they may have feelings of guilt and fears of discovery which give the children a sense of insecurity—a consciousness, perhaps only dimly felt, that something is wrong with their home.[3] The problem of illegitimacy, if it emerges at all in these cases, will then probably emerge as a psychological problem of child guidance rather than one of the social care of the mother and young child.

[1] For a fuller discussion of this issue see P.E.P., *Planning*, No. 254, 23rd August 1946—'Mothers in Jobs'.

[2] For example because the lawful spouse of one of the partners refuses to grant a divorce.

[3] Dr. M. M. Methven, 'The Child, his Disadvantages, Medical and Psychological', in *Discussion on Illegitimacy*, reprinted by the National Council for the Unmarried Mother and her Child from the Journal of the Medical Women's Federation.

Another type of unmarried mother is the promiscuous woman who lives with a succession of men and brings or drags up a 'problem' family of step-brothers and sisters, and there the problem is probably that of child neglect which will be discussed in a subsequent chapter. The third type of unmarried mother—the girl or young woman who becomes pregnant as the result of a temporary liaison, but who is not really promiscuous—is the type to whom the most attention has been given, because it is these girls and women who are in the greatest need of social care, but who with such care hold out the greatest promise of social rehabilitation.

These girls and young women differ greatly in temperament and circumstance so that each has to be considered as an individual with her own special characteristics and problems, and it is dangerous to generalise, but workers in contact with them find that certain characteristics predominate. Thus the unmarried mother of this type is frequently young, quite possibly still in her teens.[1] She is often dull and backward, if not actually defective, with an intelligence quotient somewhere between sixty-five and ninety, and this mental inferiority may be accompanied by emotional instability and immaturity, so that she is either 'deficient in moral and social sense' or 'too childish to appreciate the moral and social implications of her actions, and too lacking in strength of character to stand against the temptations of the moment'.[2] Social background and standards also count for much, and there is some consensus of opinion that 'the majority of girls who have illegitimate children come from unsatisfactory homes, or homes where there is little sympathy and understanding between the girl and her mother, although the home may be satisfactory in other respects'.[3] Many girls have lived or worked away from home in circumstances in which they are exposed to temptations which their weakness and ignorance ill fit them to resist. Thus the majority, though not all, of

[1] The Survey of the Joint Committee of the Royal College of Obstetricians and Gynaecologists and the Population Investigation Committee found that more than a quarter of the unmarried primiparae in their sample were under twenty years old, op. cit., p. 194.

[2] Dr. Doris M. Odlum, 'The Mother—Types of Women Involved and their Reactions' in the *Discussion of Illegitimacy* just cited. Cf. the description given of 'The Problem Girl' given in a Report of the Joint Committee of the B.M.A. and the Magistrates' Association, 1946—'always at the root of her problem is some defect of character structure. . . . It is not necessarily a defect of intellect, but rather a degree of social insufficiency.' Such girls often become unmarried mothers.

[3] Op. cit., p. 13, cf. Dr. E. M. Lynton-Low in the same discussion. 'It is estimated that one-third of the girls admitted to one of the diocesan mother and baby homes came from "unsatisfactory homes" in which there has been constant friction and insecurity. The proportion is probably the same in other institutions.' Op. cit., p. 17.

the girls and young women who 'get into trouble' do so as the result of defects of intelligence and temperament combined with unsatisfactory upbringing and low moral and social standards, and are ill-fitted to cope with the difficulties their pregnancy brings with it and for the responsibilities of motherhood. For their own sakes and for the sake of their children they must receive help from the community.

Society's attitude towards the unmarried mother and her children has changed considerably since Victorian days when she was regarded as an outcast whose very existence the respectable woman was expected to ignore. In such an atmosphere even those who tried to help her were subject to misunderstanding and criticised as condoning immorality, and great credit is due to the pioneer church[1] workers who, inspired by Christian teaching and charity, braved public opinion and went to the rescue of their 'fallen' sisters. Their outlook and methods are in many ways alien to the present generation of social workers,[2] but they laid the foundations on which these can build, and their direct descendants, the 'moral welfare workers'[3] of to-day, play an important part in the social rehabilitation and community care of girls and women in trouble as the result of irregular sexual relationships.

The moral welfare worker regards the problem of illegitimacy as fundamentally an ethical and social one, and considers that a religious background to the work is essential if the girls' real needs are to be met,[4] but it has other aspects, and others have approached it in the first instance from the health angle. Thus the National Council for the Unmarried Mother and her Child, an important co-ordinating and propaganda body which has done much to further the reform of legislation affecting unmarried mothers and illegitimate children, was brought into being in 1918 as a result of the concern aroused when it was realised that the infant mortality rate

[1] 'Church' is used here in a broad sense. The workers were drawn from all denominations but chiefly the Church of England, the Roman Catholic Church and the Salvation Army.

[2] Examples of the changing outlook are given in a pamphlet entitled, *Some Aspects of Moral Welfare Work*, reprinted from *Social Work*, October 1942, by the Church of England Moral Welfare Council.

[3] The use of the word 'moral' in connection with one particular group of social and ethical problems is perhaps unfortunate, and is deplored by some workers in the field, but it has become generally recognised and no satisfactory substitute for the term 'moral welfare worker' has yet been found.

[4] 'It is no use talking about "How can we help the girl to leave her immoral life" unless we are prepared to say what is right conduct, and we can only say what is right in relation to what we believe to be true to our religion. Unless the people who are doing this work have something to give on these lines they are not meeting the girl's fundamental need.'—Miss E. M. Steel, Organising Secretary, Church of England Moral Welfare Council.

among illegitimate children was twice as high as among those born in wedlock. The gap between the two rates has persisted, although it has narrowed slightly with the passing of the years,[1] and the existence of this gap, together with the increase in the proportion of illegitimate births, which was one of the social consequences of the Second World War,[2] led the Ministry of Health to take action, and in 1943 it issued a circular[3] to local authorities urging them to make special provisions for the care of the unmarried mother and her child. This circular encouraged local welfare authorities to co-operate with and reinforce the work of voluntary moral welfare associations, and suggested that every welfare authority should formulate a scheme for the purpose. Moreover, the Ministry considered that, in order to further the working of such a scheme, a trained worker, experienced in the special problems she would have to handle, should be appointed wherever possible. Her duties would include co-operation with voluntary associations and health visitors in advising and assisting the girl with her social and legal problems, finding accommodation for her and the child, and in special cases giving advice about legal adoption. The response of the local authorities to this circular has varied. Some have appointed special workers, but others have left the work to the health visitors, and the Report of the Ministry of Health for the year 1947–8 suggested that the Minister was not entirely satisfied with the co-operation which had been achieved in some areas between the welfare authorities and the voluntary associations. It urged that where moral welfare workers are available every effort should be made to take advantage of their knowledge and experience.[4] Health authorities and moral welfare associations are not the only agencies involved in this situation, however. The girl may seek financial help from the National Assistance Board, or if her need is desperate, residential accommodation from the social welfare

[1] Deaths of infants under one year of age per 1,000 live births, England and Wales, legitimate and illegitimate infants.

	Legitimate	*Illegitimate*
1914	100	207
1918	91	186
1938	52	81
1949	32	45

[2] Illegitimate births per 1,000 total live births, England and Wales.

1918 ..	63	1945 ..	93
1938 ..	42	1947 ..	53
1942 ..	56	1949 ..	51

[3] Ministry of Health Circular 2866, *The Care of Illegitimate Children.*

[4] Report of the Ministry of Health for the year ended 31st March 1948, Cmd. 7734, p. 110. Cf. Report for 1949–50, Cmd. 8342, p. 56.

authority,[1] and it is important that the officials administering these services should be aware of those provided both by the public health authorities and the moral welfare associations, and the utmost degree of co-operation be achieved in the interests of both mother and child.

The problems which face the single pregnant woman are both social and legal. At some time she must tell her parents, and perhaps face their disapproval or rejection, though this is rarer now than a generation ago, and sooner or later her employer and fellow workers will learn of her condition. Her relationship with the putative father must be defined, arrangements must be made for the confinement, and above all, there is the future of the child to be considered. To help her deal satisfactorily with these problems she needs the support of a disinterested friend—an understanding woman with knowledge and experience who will not condone her folly and weakness, nor yet reject her because of it, but will help her plan constructively for herself and her child. This friendship and support should be the contribution of the social worker, whether she be employed by the local authority or by a moral welfare association.

The most important question that has to be settled is that of the future of the child, but this is dependent to some extent on the position and attitude of the putative father, and the girl's relationship with him. The situation may vary from one in which two young people have but anticipated their wedding day, and are anxious to regularise their position as soon as may be, to one in which the man is married and can do little or nothing to help the girl, or in which he denies paternity altogether. While there are still those, particularly perhaps among the girl's relations if she comes from a respectable family, who would give the child a name at all costs, it is now generally recognised that even if there is no legal bar, marriage is in itself no real solution to the problem and if entered into unwillingly simply because there is a child on the way, may result in lasting unhappiness to father, mother and child.

A child born out of wedlock whose parents subsequently marry may be made legitimate under the terms of the Legitimacy Act, 1926, but there must have been no bar to marriage at the time of the child's birth.

In law the mother is the sole guardian of an illegitimate child, but she may apply to the magistrates' court for an affiliation order

[1] Until 5th July 1948, she would obtain financial assistance, accommodation if necessary, and a measure of social care from the local authority Public Assistance Service. The division made by the National Assistance Act between financial assistance and welfare services complicates the position here and increases the need for co-operation between workers of all kinds.

which, if granted, will impose a legal liability on the putative father to make weekly contributions towards the child's maintenance. Very few unmarried mothers attempt to obtain such orders, however.[1] Corroborative evidence may be hard to obtain, the girl may dread the court appearance and the inevitable questioning, which may have to be very detailed to ensure that justice is done to both parties, or her pride may prevent her from seeking redress from a man who has 'let her down'. Even if an order is obtained it may be difficult to enforce, and it is all too easy for the father to evade his responsibilities and leave the girl to carry her burden alone.

Left with no prospect of marriage the girl has to decide on her own future and that of the child. The crucial issue is whether she will accept continuing responsibility for its care, even if she has to place it in a day or residential nursery or with a foster mother while she goes out to work to maintain it, or whether she will surrender it for adoption or placement in a home. While no general rule can be laid down since circumstances and attitudes vary so much from case to case, the consensus of opinion among health and social workers would seem to be that in the majority of cases everything possible should be done to enable the mother to keep her child, since early separation may have harmful physical and psychological effects on them both.[2] It appears from such statistics that are available that the majority of unmarried mothers do, in fact, keep their babies, and a large proportion of them take them to their parents' home.[3] In many cases this is quite a satisfactory solution, the child is absorbed into the family, and little further social care is needed, but this must not be taken for granted. It has already been suggested that unsatisfactory home conditions may be a major contributory factor in a girl's downfall, and neither physical conditions nor human relationships are likely to be improved by the addition of an illegitimate child to such a family, while in families with higher social standards future difficulties may be created by attempts to conceal the child's relationship with his mother. Skilful and unobtrusive social case work may be

[1] In 1949 there were 37,064 illegitimate births, but only 4,956 applications for affiliation orders, of which 4,097 were granted.

[2] Dr. Dorothy Taylor, Senior Medical Officer, Maternity and Child Welfare, Ministry of Health, speaking at a conference arranged by the National Council for the Unmarried Mother and her Child in November 1945, said, 'I emphasise the fact that in the Ministry we are anxious to pursue a policy which would enable the mother to keep her child with her', but cf. J. Bowlby, *Maternal Care and Mental Health*, ch. x.

[3] Sometimes the grandparents wish to adopt their daughter's illegitimate child. These cases (an example of which is given in *The Almoner*, Vol. III, No. 9, December 1950, pp. 327–30), may involve serious emotional strains and require careful investigation.

needed at least for a period after the girl's return home if the child is to have a chance of growing up adjusted and secure.

Should the unmarried mother be unable or unwilling to take the baby home alternative forms of accommodation and care must be considered. A very valuable form of care, especially for young mothers with their first babies, is the maternity home where the girl can stay for some weeks before and after the birth of her child, for here, if it is run by a wise and understanding superintendent, she will not only receive the physical care she needs, but training in child care, and guidance, based on knowledge of her personality and circumstances, as to her future and that of the child. When she leaves the home or hostel the mother will have to obtain some kind of nursery or foster care for the child, or, possibly, lodgings where the landlady will look after it in her absence. Advice and help are needed in all these matters, and here again the help of the moral welfare worker or other social worker may be invaluable, especially as this period of readjustment to more normal life may be a very difficult one, during which the girl will need all the strength and support she can obtain.

Should it be impossible, or for any reason undesirable, for the mother to retain the responsibility for the child's care and maintenance, adoption is the alternative usually envisaged, and the Curtis Committee considered that 'if successful it is the most completely satisfactory method of providing a substitute home'.[1] But, since it involves the complete surrender of all parental rights, and their assumption by the adoptive parents, it calls for careful thought on the part of all concerned, and strict legal safeguards to protect the interests of the child.

Legal adoption was first made possible by the Adoption Act, 1926. The law governing it was strengthened by the Adoption of Children (Regulations) Act, 1939, and by the Adoption of Children Act, 1949, and this legislation has now been consolidated by the Adoption Act, 1950.

Application for an adoption order may be made either to a High Court, a County Court or a Juvenile Court, but the vast majority of cases are heard in the Juvenile Courts.[2] Procedure in all courts is governed by the Acts mentioned above and their attendant regulations, and it has been carefully devised to safeguard the interests of all three parties concerned—the child, the natural parents, and the adopters. The two last can speak for themselves, but the child is in all cases relatively, and some cases completely,

[1] Report of the Care of Children Committee, Cmd. 6922, 1946, par. 448, p. 148.

[2] Out of the 17,317 adoption orders made in 1949, 199 were made in the High Courts, 4,337 in the County Courts, and 12,781 in the Juvenile Courts.

helpless and inarticulate, so the Court is bound to appoint a guardian *ad litem*, whose duty it is 'to investigate as fully as possible all circumstances relevant to the proposed adoption with a view to safeguarding the interests of the infant[1] before the Court, and to make a report to the Court for that purpose'.[2]

As has already been pointed out, the effect of an adoption order is that all the rights, duties, obligations and liabilities of the natural parents are extinguished, and vested instead in the adopter, 'as if the infant were a child born to the adopter in lawful wedlock'.[3] Hence before an order is made, the court must be wholly satisfied both that the adopters are suitable persons to take over the custody of the child, and fully understand the nature and extent of the responsibilities they are assuming, and that the natural parents or guardians have ample time to consider the consequences of their decision to surrender the child.

Applicants for an adoption order who are not related in any way to the infant they are proposing to adopt must have attained the age of twenty-five, and must be at least twenty-one years older than this infant. Relatives of a child may adopt it if they have reached the age of twenty-one, however, and no minimum age is laid down where a parent is adopting his or her own child.[4] All applications for adoption must be carefully investigated by the guardian *ad litem*, who in making the investigation should take into account motivation and emotional attitudes as well as material conditions such as health and financial circumstances, and in any case must make sure that the adopters really appreciate what they are doing.[5]

Although in the last resort a great deal depends on the knowledge and insight of the guardian *ad litem*, the provisions of the Adoption Acts and the Statutory Instruments accompanying them go a long way towards ensuring that only those who really want to bring up another person's child as their own and who are compe-

[1] The word 'infant' here and throughout this discussion is given the legal connotation it is given in the Adoption Act, 1950. It means a person under twenty-one years of age, but does not include a person who is, or has been, married.

[2] Adoption of Children (Summary Jurisdiction) Rules, 1949, S.I. 1949, No. 2397 (L.32), par. 7.

[3] Adoption Act, 1950, Section 10 (1).

[4] Adoption Act, 1950, Section 2 (1). Parents of an illegitimate child may adopt it if they subsequently marry, but are not able to legitimise it under the terms of the Legitimacy Act, 1926; or a mother who marries a third person who is willing to make the child a full member of his family, may adopt it jointly with her spouse, or singly with his consent, in order to regularise its position.

[5] The information which the guardian *ad litem* must obtain and report to the court is set out in the Second Schedule of the Adoption of Children (Summary Jurisdiction Rules), 1949, S.I. 1949, No. 2397 (L. 32), p. 15.

tent to undertake this delicate and difficult task will be given the opportunity of doing so. Equal care is taken to see that the adoption is not made without the full knowledge and considered consent of those from whom the child is being taken. Thus an adoption order cannot be made without the consent of the child's parent or guardian unless he or she has abandoned, neglected or persistently ill-treated him, in which case the court may dispense with it. Persons liable by virtue of an order or agreement to contribute to the child's maintenance, for example, the putative father of an illegitimate child against whom an affiliation order is in force, must also give their consent to an adoption order, unless they have persistently failed to contribute. Consent may be dispensed with where the person concerned cannot be found or unreasonably withholds it. Refusal by a parent is regarded as unreasonable only if his or her attitude is one unreasonable for a parent, whether or not the welfare of the child would be promoted by the adoption.[1] The infant's consent is not needed but the court must give due consideration to his wishes having regard to his age and understanding.[2]

Some of the most important additional safeguards introduced into the Adoption Acts of 1949 and 1950, were designed specifically to lessen the possibility of a mother agreeing too readily to the adoption of her child, but afterwards regretting it, and 'snatching back' the infant from the care of the adopters while the proceedings were still going on. Thus in order that the mother may have time to recover from the physical and psychological strains of childbirth before making so important a decision, her consent is not valid if given before the child is six weeks old. Furthermore, an order cannot be made until the infant has been continuously in the care of the applicant for at least three months, a period which gives both adopter and natural parent a chance to discover what adoption will mean. The mother may recover her child, and proceedings be brought to an end during this trial period, but only with the consent of the court, and in considering whether to give or withhold consent, the court must have regard to the welfare of the child.[3] As an additional safeguard for the child during this probationary period the applicant must inform the 'welfare authority'[4] when he takes the child into his care with a view to adoption, and

[1] The provisions about 'consent' are in the Adoption Act, 1930, Section 2 (4), 3 and 4. Hitchcock *v.* W.B. (1951); Re K. (an infant) Rogers *v.* Kuzmicz (1952).

[2] Ibid., Section 5 (2). The Adoption of Children Rules, 1952, make it a duty of the guardian *ad litem* to satisfy himself if the child is of an age to understand the order, and if he is and has not been informed of the application and its effects, to inform him.

[3] Ibid., Section 3 (4).

[4] In England this means the welfare authority for the purposes of the provisions relating to child life protection of the Public Health Act, 1936, that is, for the vast majority of local authorities, the Children's Department.

if the welfare authority takes its responsibilities seriously, this should mean that a trained and experienced social worker will then be in touch with the case. She will be able to help both the child and his prospective parents over their initial difficulties, and judge if he is likely to settle happily and be well cared for in his new home.

Adoptions may be arranged by the parties directly concerned, or through the medium of a third person or organisation. It was to regulate these 'third party' adoptions that the Adoption of Children (Regulations) Act, 1939, was passed, and its main provisions have now been incorporated in Parts II and III of the Adoption Act, 1950. These provisions prohibit any body of persons other than a local authority or a society registered as an adoption society by the County Council or County Borough Council within whose area its administrative headquarters are situated, from making arrangements for adoptions, while private persons who assist in any way in the placing of children must notify the appropriate welfare authority. Only associations recognised by law as 'charitable' may register as adoption societies, and in addition they must show that their affairs are properly managed by a responsible committee, which includes a sufficient number of 'fit and proper' persons to make arrangements for the adoption of children on the society's behalf.[1] Regulations passed in 1943, which still hold good, prescribe the information which must be given to a parent or guardian who is proposing to place a child with the society for adoption, the information to be obtained in connection with the placing, and the arrangements to be made for the supervision of the children who are in the care of the society pending adoption.

The arrangements just outlined appear to provide reasonable safeguards for the child placed with an adoption society, but the position of a child in whose placing a private person takes a hand or whose mother makes her own arrangements without any intervention is still not satisfactory. There does not appear to be any public supervision or investigation in the last type of these cases unless or until an application for an adoption order has been made and the court appointed a guardian *ad litem*, or the welfare authortiy has been informed by the would-be adopter that he has taken the child into his care for the statutory three months' probationary period. Thus the child whose mother simply passes it over to another person without monetary exchange, and without proceedings for adoption being initiated, is still unprotected, and the extent to which this practice is carried on and its consequences for the child would seem to call for public action.[2]

[1] Adoption Act, 1950, Section 23 (4).

[2] See speech by Dr. Somerville Hastings in the House of Commons Debate, 12th December 1949. Parliamentary Proceedings (*Hansard*), Vol. CCCCLXX, No. 204, col. 2449.

Thus the legislation concerning adoption goes a long way towards minimising, although it does not entirely do away with, the risk of an irresponsible, disturbed or unstable mother handing over her child for adoption by unsuitable persons; while at the same time it gives the child whose parents are unable to provide him with the care and affection which should be his birthright a chance of finding security and happiness in the bosom of another family. Nevertheless there is still room for improvement in both procedure and practice, and in January 1953 a Committee was set up under the aegis of the Home Office and the Scottish Home Department to consider the present law relating to adoption and report whether any, and if so what, changes in policy or procedure are desirable in the interests of the children concerned. No fundamental changes in law or procedure are recommended by the Committee;[1] it is concerned that the law should be strengthened where it is weak and clarified where it is ambiguous rather than it should be greatly altered. Strengthening and clarification are particularly needed in connection with direct and third party placings. The Committee considers that their complete prohibition would neither be desirable nor practicable at the present time since this would be likely to lead to an increase in the number of *de facto* adoptions. It suggests that the obligations of both third parties and persons receiving children should be tightened up, in the former case by making them respondents to the application, in the latter by making it a requirement for any person (except a guardian or relative) who is about to receive a child, except from a local authority or an adoption society, to give fourteen days' notice to the local authority of the area in which he lives. To remove any ambiguities with regard to the local authority's powers and duties as supervisory authority and to make sure that all types of placements are properly supervised, it recommends that in all cases where a child is placed for legal or *de facto* adoption, whether through a third party or direct by his parent, in all cases where notice of intention to apply for adoption is given; in all cases where a local authority places a child for adoption outside its own area or a child is placed by an adoption society, the child concerned should be subject to statutory supervision as a foster child within the meaning of the existing child life protection provisions.[2] This involves an obligation to notify the local authority seven days before taking the child and subsequent supervision by a child life protection visitor who has right of entry in order to satisfy herself as to

[1] Report of the Departmental Committee on the Adoption of Children. Cmd. 2498. September 1954.

[2] Ibid., paras. 27, 37, 43–51, 63. Children Act, 1948, Part V; Public Health Act, 1936, Part VIII, Sections 206–20.

the health and well-being of foster children. Such children may be removed to a place of safety if the premises in which they are being kept are overcrowded, insanitary or dangerous or the person looking after them is unfit to have care of them.

Other recommendations made by the Committee concern consents and include an attempt to get over the present difficulty with regard to consents unreasonably withheld. It is suggested that these words be repeated and a provision added allowing the court to dispense with a parent's consent if he had made no attempt to discharge his parental responsibilities. Suggestions are also made about procedure, court proceedings and transfer abroad, all of which are designed to safeguard the welfare of the child. At the time of writing[1] amending legislation incorporating these suggestions has not yet been brought before Parliament.

[1] January 1955.

CHAPTER XI

THE HEALTH AND WELFARE OF THE SCHOOL CHILD

AT THE age of two, if he is one of the fortunate few for whom there are places in nursery schools, at the age of five otherwise, the child passes into the care of the Local Education Authority for the area in which he lives. Henceforth, at least until the end of the term following his fifteenth birthday,[1] this authority has a large measure of responsibility, not only for increasing his knowledge and skills by means of formal instruction, but also for his 'spiritual, moral, mental and physical development'—the declared aim of education to-day.[2]

This wider conception of education was born with difficulty and grew slowly, however, and the pioneers of school feeding and school medical inspection and treatment, often the teachers and inspectors who knew from first-hand experience how great was the need, had a hard struggle to convince both legislators and the public generally that, in accepting responsibility for the education of its children, the nation had, whether wittingly or not, accepted responsibility for their health and general well-being, since the effective discharge of one responsibility was impossible without undertaking the other. Further, these pioneers had not only to contend with the passive resistance of the indifferent, but also with the active opposition of those who regarded any material help given by the State, unless safeguarded by a deterrent Poor Law, as a threat to family solidarity and responsibility.[3]

The first major victory for the reformers was the Education (Provision of Meals) Act, 1906, which empowered Local Education Authorities to provide milk and meals to elementary school children who were 'unable by reason of lack of food to take full advantage of the education provided for them'. Modest as its provisions were, this Act established two important precedents. In the first place, it is the earliest example of relief from public funds being

[1] When Section 43 of the Education Act, 1944, is implemented, and county colleges become part of the educational system, the health and welfare services of the Local Education Authorities will also cover young people of fifteen to eighteen.

[2] Education Act, 1944, Section 7.

[3] Cf. Chapters IV and X, above.

given to a specific section of the population by an agency other than the Poor Law, and hence it marks the beginning of the break up of that formidable structure, and is the forerunner of the social assistance services of the twentieth century.[1] Secondly, it established the principle that education extends beyond instruction to social care, even if in order to do this it had to state specifically that the social care provided was not an end in itself, but a means to enable the child to take full advantage of the formal education for which the public was paying rates and taxes.[2]

The Act was then important, but it had its limitations. Both it and its successor, passed in August 1914, which made it possible for the Board of Education to make grants in respect of school meals, were permissive, and by 1939 only 151 of the 316 Local Education Authorities in the country were providing solid meals, and 41 authorities did not even provide milk. Meals were limited to children unable otherwise to take advantage of the education provided, and could only be given free when the parents could not afford to pay for them. Hence, strictly speaking, if a child were to receive a free dinner, he had to show both that he was undernourished and that his parents were too poor to feed him properly. The establishment of the school medical service in 1908 provided the machinery by which children could be selected for meals on grounds of malnutrition, but in fact the assessment of nutrition has proved a difficult and unsatisfactory business.[3] As time went on some Local Education Authorities dispensed with the medical test altogether and based their selection on family income and needs alone, arguing that if a child came from a home where there was acute poverty, malnutrition was almost inevitable, and preventive measures should be taken before the clinical symptoms became apparent.[4] Between 1920 and 1930 the Board of Education

[1] Notice that it was relief in kind that was given. Non-contributory old age pensions, the first statutory cash grants apart from the Poor Law, were introduced two years later by the Old Age Pensions Act, 1908.

[2] Cf. F. le Gros Clark, *Social History of the School Meals Service*, National Council of Social Service, 1948, p. 9. 'It [i.e. the Education (Provision of Meals) Act] removed the feeding of the children from the shadow of the relieving officer, at all events in intention, and it established the principle that the provision was part of the educational process of the child's life.' This booklet gives an interesting account of the history of the service from its inception to the coming into force of the Education Act, 1944, in April 1945, and forms the basis of a good deal of this and the following paragraph.

[3] Cf. Ministry of Education, *The Health of the School Child*, Report of the Chief Medical Officer of the Ministry of Education for the years 1946 and 1947, pp. 11–13; R. Huws Jones, 'Physical Indices and Clinical Assessments of the Nutrition of Schoolchildren', *Journal of the Royal Statistical Society*, Vol. CL, 1938.

[4] See also P.E.P., 'Child Health and Nutrition', *Planning*, No. 248, 18th April 1946.

acquiesced in this policy, and allowed that a child might be selected for free meals either because of poverty or because of malnutrition; but this was challenged by the May Committee in the economic crises of 1931, and henceforth the administrators of the Board were forced to insist that a child could not receive a meal at less than the cost of the food unless he was both necessitous and showed clinical symptoms of undernourishment.

Except in those areas where married women's work was common very few families who could afford to contribute to the cost of the meals took advantage of the service, and in general the acceptance of school meals was regarded as an admission of inability to feed one's child, and hence as something to be avoided at all costs by the self-respecting, many of whom refused to allow their children to partake of dinners although they were entitled to do so. Moreover, in some areas, the quality of the food provided, the standards of cooking, and the conditions under which it was served were unsatisfactory, and this further accentuated the association of the service with poverty and degradation. On the other hand the more enlightened authorities were endeavouring with some success to make the school meals an opportunity for social training and the inculcation of healthier food habits.

In 1934 the Milk Act made it possible for school children to obtain a third of a pint of milk per day for a halfpenny (free in necessitous cases), and on the eve of the last war about half the children in the country were benefiting from this provision.

The economic and social repercussions of the six years of war brought about developments which completely changed the character and scope of the school meals service.[1] The demand for married women workers in the factories meant that mid-day meals must be provided for the school children, just as it necessitated the provision of nurseries for their younger brothers and sisters. Moreover, the maintenance of a high level of nutrition amongst the children of the nation, whatever the hardships or deprivations suffered by adults, was a major objective of the government's food policy, and school meals were regarded as a form of differential rationing directed towards this end. Hence in 1940 the Board of Education issued a circular recommending the establishment of communal feeding arrangements whether free of charge or for payment for children whose needs were not fully met by the normal provision of food in their own homes,[2] and during the succeeding years efforts were made to extend the service and free it from its

[1] These are described in detail in *The Health of the School Child during Six Years of War*, Report of the Chief Medical Officer of the Ministry of Education, 1939–45.

[2] Board of Education Circular 1520, July 1940.

old association with poverty and the means test. The 'feeding centre' was gradually transformed into the 'school canteen', and by February 1944 32·8 per cent of the number of pupils present were having dinners, a total of which may be compared with the 4·4 per cent of the public elementary school children receiving dinners in 1938–9.

The Education Act, 1944, and its attendant regulations[1] set the seal on this new conception of the school meals service, by making it a duty of the Local Education Authority to provide milk, meals, and other refreshment for day pupils in attendance at schools and county colleges maintained by them, but, owing to the material and financial shortages of the post-war years, the promised land of free school meals for all children who wish to take advantage of them is still distant.[2] By October 1948, nearly 2,750,000 or 56·6 per cent of the total number of pupils in grant-aided schools were partaking of meals, while during the same year 88 per cent took advantage of the milk in schools scheme.

The primary aim of the school meals service is the adequate nutrition of all the nation's children, but it is intended to do more than this. The school meal is regarded in many quarters as an opportunity for social training, and for the inculcation of good food habits, both very important items in the education of all children, particularly perhaps in that of over-indulged only children, or those from homes where the mother's ignorance of food values is matched by her indifference to them. If anything worth while is to be done in the way of social training however, the meals must be properly supervised, served in an orderly manner, preferably with the help of the children themselves, and eaten without haste in a happy atmosphere and pleasant surroundings. Unfortunately these conditions are not being fulfilled in many canteens to-day. Too often the premises are make-shift and overcrowded, the supervisors harassed, the meal bolted and the children hurried out to make room for a second batch. Shortages of premises, staff and equipment are largely responsible for this state of affairs, but until they are overcome the school meal cannot be fully effective as an integral part of the child's education.

Legislative sanction for the medical inspection and treatment of school children soon followed the sanctioning of the meals service, and the initial action taken was even stronger, for while the Educa-

[1] Education Act, 1944, Section 49; S.R. and O. 1945, No. 698 and Circulars 34/45, 96/46 and 119/46.

[2] Free meals and milk were promised as a supplement to family allowances when these were introduced, and were taken into account when fixing the rate of the allowance. See Chapter II above. Milk in schools was provided free after the introduction of the family allowances, but payments have still to be made for solid meals except in necessitous cases.

tion (Provision of Meals) Act empowered Local Education Authorities to provide meals to necessitous school children, the Education (Administrative Provisions) Act of the following year compelled them to have the children in elementary schools medically examined at least three times during their school career. Unfortunately, the bogy of undermining parental responsibility and the fear of intruding into the sphere of the private doctor, prevented an equally strong line being taken with regard to the provision of facilities for treatment, and this remained optional for a number of years.

The need for medical examination and treatment had long been apparent to those who had eyes to see. Thus, Margaret McMillan, when she became a member of the Bradford School Board in 1894, was horrified by what she saw in the schools. 'Children in every stage of illness, children with adenoids, children with curvature, children in every stage of neglect and dirt and suffering.' The condition of the poorer children was worse than anything described or painted, 'the half timers slept exhausted at their desks, and from courts and alleys children attended school in all states of physical misery'.[1] The findings of the school doctors, when examinations were begun throughout the country twenty years later in 1908, confirmed these impressions. In Liverpool, for example, the early examinations revealed evidence of verminous infestation in over 80 per cent of the girls seen, while 40 per cent of boys and girls were dirty in body and clothing. Very few children appeared to have had any conservative care given to their teeth, and numerous untreated cases of deafness, running ears, defective vision and crippling conditions were discovered.[2] Liverpool's findings were paralleled in populous areas in other parts of the country and some local authorities, at least, realised the overriding necessity of providing treatment to deal with such conditions, and went ahead to appoint more school medical officers and establish clinics. Others, influenced by the same fear of pauperising the parents or of offending the practitioners, which had precluded mandatory legislation, relied at first on children receiving treatment from their own doctors or through the out-patient departments of the hospitals. They were at length convinced by the long list of untreated cases in their books that action must be taken. Gradually school clinics were established throughout the country and the number and variety of defects treated increased.

The Education Act, 1944, makes both 'medical inspection at appropriate intervals' and 'the provision of free medical treatment'

[1] Margaret McMillan, *The Life of Rachel McMillan*, pp. 80 and 89.

[2] City of Liverpool, Report of the Education Committee for the municipal year 1947–8, pp. 102–3.

for pupils in schools or colleges maintained by them, statutory duties of Local Education Authorities.[1] To-day routine medical inspections take place three times during the pupil's school career, on entry, during the last year in the primary, and during the last year in the secondary school. Regulations issued in 1953[2] give local medical officers greater freedom to experiment with the number and type of inspections. Inspection on not less than three occasions remains the general rule, but this may be modified with the consent of the Minister, whose approval or not of the changes proposed will depend on 'the extent to which they appear likely to make a positive contribution to the efficiency of the preventive work of the school health service'.[3] Routine inspections are everywhere supplemented by special inspections if the teacher or anyone in contact with the child notices anything wrong, or if the doctor considers a re-examination necessary, and the importance of these special inspections can be judged by the fact that in 1953 the number of special and re-inspections in England and Wales (2,388,900) considerably exceeded that of routine inspections (2,068,375).[4] In addition to the medical inspections, dental and cleanliness inspections are held at intervals. Unfortunately the shortage of dentists, which has become even more acute since the implementation of the National Health Service Act, as Local Education Authorities are unable to offer financial inducements comparable with those of general practice within the framework of the health service, means that dental inspections take place much less frequently than is desirable.

Recent general and special inspections show that there has been considerable improvement in the children's health and general care, both at home and at school, during the last forty years[5] but there are still black spots, mainly the result of poor living conditions and lack of parental care. For example, the Report of the Chief Medical Officer of the Ministry of Education for the years 1946 and 1947 describes the statistics relating to verminous infestation as 'profoundly disappointing'.[6] It attributes this not so much to any failure of the cleansing service, as to 'the reservoir of infestation

[1] Education Act, 1944, Section 48.

[2] The School Health Service and Handicapped Pupils Regulations, 1953. Regulation 10 (i) (a).

[3] Circular 269 (25th August 1953).

[4] *The Health of the School Child.* Report of the Chief Medical Officer of the Ministry of Education for the years 1952 and 1953, p. 10.

[5] Liverpool Education Committee, op. cit., p. 104, cf. City of Salford Education Committee Report of the School Medical Officer for the year ended 31st December 1948, pp. 7 and 8; G. A. N. Lowndes, op. cit., pp. 223–5.

[6] Op. cit., pp. 44–5. The number of individual children found to be infested was 486,640 in 1946 and 471,342 in 1947. These figures showed some improvement over those of the war years, but were about the same as those for the years immediately preceding the war. In 1953 the number infested was 316,854.

which is produced by insanitary living conditions and ignorance, in some cases neglect, on the part of patents'. Bad housing, shortage of washing materials, and the employment of mothers, are mentioned as specific factors operating to maintain a high infestation rate, and the Chief School Medical Officer considers that 'while they remain and are combined with carelessness and indifference on the part of a small section of the population, cleanliness work in the schools, however much expanded, will be mainly palliative'.[1] The school health service in this as in other respects, is essentially an educational service, and probably the most important function of the school nurse, who now receives health visitor training, is that of visiting the homes of children in need of care and helping and encouraging the parents to make full use of the professional services available so that they give their children really adequate health and social care.

Since the school health service has a strong educational bias and is closely linked with health education, it is understandable that it should remain in the main a responsibility of the Ministry of Education and the Local Education Authorities. Nevertheless, the implementation of the National Health Service Act has made important differences to the position, particularly with regard to treatment. The administrative arrangements which are now in operation were agreed upon as the result of consultation between the Minister of Education and the Minister of Health, and are set out in Ministry of Education Circular 179, issued in August 1948. This circular points out that the work of medical inspection and the ascertainment of handicapped pupils is not affected by the establishment of the National Health Service, but the position is different in regard to specialist treatment, as this has become part of the hospital and specialist services organised by the Regional Hospital Boards for the population as a whole. This means that consultative and specialist treatment given by arrangement with the school health service in a hospital or clinic attached to it is now free of charge, both to patient and to the Local Education Authority. With regard to specialist work hitherto carried out in school clinics, the Ministry of Health has advised the Regional Hospital Boards that 'it will normally be appropriate for them to take over

[1] Ibid., cf. Women's Group on Public Welfare, *Our Towns, a Close-up*, 1943, pp. 66–75. This book quotes the findings of a survey made by Dr. Kenneth Mellanby, and published in 1941, into *The Incidence of Head Lice in England*. The most important conclusions were that the incidence of head lice as revealed by thorough examination of hospital patients is much higher than the comparable incidence in the school medical officers' reports, and that the highest rate of infestation is among pre-school children. These children thus form the reservoir of infestation in the home which defeats the best efforts of the school health service. In some families head lice are a 'family complaint' and a matter of indifference, and their eradication is a matter of social education.

also responsibility for providing out-patient specialist services for school children hitherto provided by Local Education Authorities at school clinics or other premises, which are not transferable'.[1] 'The Health of the School Child' for 1950–51 discusses the working of those arrangements and relations between the school clinic and the family doctor. It urges that full use be made of the facilities provided by the school health service, and the frank exchange of information, as does also the Report for 1952–3.

Throughout the greater part of the country the responsibility of following up medical inspections and making home visits in connection with treatment rest with the school nurse, who is the recognised link between the school health service and the home. The London County Council has also a 'care committee' attached to each school or group of schools. Each committee consists of a group of voluntary helpers working under the guidance of a trained social worker who is employed by the Council. The scheme is thus interesting and significant not only as an experiment in a particular form of child care, but as 'an attempt to utilise the spirit of social service in the private citizen in a sphere in which full public responsibility has been accepted'.[2] It arose shortly after the inception of the school meals service and school medical inspection, as a means of maintaining effective contact with the homes of children receiving meals or found at medical inspections to be in need of special care, and was designed in the first place to ensure that the children derived the maximum benefit from these publicly provided services. However, it is claimed that it has now become a form of social case work, centring on the school child, but through him impinging on the life of the family as a whole. In the true case work tradition the child is regarded not as an isolated individual, but as a member of a family whose total needs must be considered in relation to him,[3] and thus the outlook of the care committee organiser is social rather than medical, and the scheme more nearly approaches a general welfare service for children than anything in the provinces. At the same time it suffers from the difficulties and shortcomings apparently inseparable from reliance on voluntary workers, the most serious of which is a chronic shortage of suitable volunteers. 'There never has been a sufficiency of volunteers either in quantity or quality to make possible the adequate staffing of every school care committee in the London County Council Area', writes Miss Eileen Younghusband.[4] Never-

[1] Quoted in Ministry of Education Circular 179, 4th August 1948.

[2] Hilda Jennings, *The Private Citizen in Public Social Work*, 1930, p. 19.

[3] Cf. 'Three Aspects of School Case Work, a Changing Emphasis', *Social Work*, Vol. III, No. 7, July 1945.

[4] *Report on the Employment and Training of Social Workers*, Carnegie U.K. Trust, 1946, p. 82.

theless she concludes that 'this method of linking school and home is a considerable advance on the usual system of entrusting the follow up of school medical inspection to the school nurse and providing no general welfare service between school and home'. While the extensive development of voluntary service on the care committee lines in other parts of the country is unlikely, the value of extending and co-ordinating the health and welfare services for children by some means or other is widely recognised. The necessity for such extension and co-ordination is seen particularly in those cases where the child is suffering from parental ignorance and neglect, and the measures which have recently been taken to encourage further co-operation between all statutory and voluntary organisations concerned with the welfare of children in their own homes are intended to deal more effectively with this condition. They will therefore be discussed in Chapter XIII.

CHAPTER XII

PROVISIONS FOR THE TREATMENT OF HANDICAPPED CHILDREN

AMONG the problems which were brought to light by the introduction of compulsory education was that of the education and care of the physically or mentally handicapped child. It is a medical and social as well as an educational problem, and during the last fifty years progress has been made in all these respects, so that the outlook for the handicapped child to-day is far brighter than that of his counterpart of three generations ago. Advances in medical science, improvements in standards of living, and the higher standards of child care which have resulted from the patient educational work of the health visitors and others associated with the maternity and child welfare and the school health services, have combined to reduce considerably the extent and severity of many of the physical handicaps afflicting children. For example, Dr. J. L. Burn points out[1] that among the school child population aged five to sixteen the incidence of blindness declined by almost half in the years between 1923 and 1943, owing largely to the decline in the incidence of infectious diseases affecting the sight; while the decline in the number of seriously deformed or crippled children has been equally striking, thanks to the almost complete elimination of gross rickets and the lessening incidence of surgical tuberculosis. Great as these advances have been, there are, however, still many children suffering from physical or mental handicaps which may be both severe and permanent. For these children special educational treatment and, in many cases, social care are needed if they are to make the most of the abilities they have, and grow into well-adjusted adults with the maximum degree of economic and social self-reliance permitted by their particular disabilities.

In the early days of compulsory education little or no attempt was made to provide special educational treatment for physically or mentally handicapped children. If they could manage to get to school at all they languished alongside their more fortunate fellows, adding to the burdens of the already overburdened teacher, as was

[1] *Recent Advances in Public Health*, pp. 134–5.

demonstrated by a headmistress who told the Cross Commission in 1887 that during the previous year she had had in a single standard two children paralysed, one an idiot unable to walk but kept at school to enable an older sister to attend, one obviously 'dull', and eight so delicate that they were in constant attendance at hospital.[1] Those who were too infirm to manage the journey to school remained at home, neglected and uneducated, with no prospect other than the workhouse when they grew up and parents or other relatives were no longer able to care for them. In some areas voluntary organisations were already at work, making what provision they could for the education and care of the obviously handicapped such as the blind,[2] but the problem was too vast a one to be left to voluntary effort, and by the end of the century it was clear that the State must take action.

The first Act making specific provisions for handicapped children was the Elementary Education (Blind and Deaf Children) Act, 1893, which empowered school authorities[3] to pay for the education and maintenance of blind or deaf children in residential schools. This Act recognised that children so handicapped needed a special type of education, and provided that schools for them should operate under a special code. Furthermore, in order that they should have a longer period of education to help compensate them for their handicap, it raised their school-leaving age two years beyond that of their contemporaries who could both see and hear.

The need of special educational treatment for blind and deaf children was so obvious that it is not surprising that these were the first to be singled out for special care, but by the end of the century the necessity for making provision for the mentally defective and epileptic had been officially recognised by the Education (Defective and Epileptic Children) Act, 1899,[4] and the Passmore Edwards Settlement in London had started the first school for cripples. By 1921 the principle of providing all types of handicapped children with the instruction and care best suited to their needs had become well established, and the Education Act of that year imposed on

[1] Quoted G. A. N. Lowndes, op. cit., p. 164.

[2] The first school for blind children was established in Liverpool in 1792.

[3] Until the implementation of the Education Act of 1902 the School Boards, afterwards the Local Education Authorities.

[4] Voluntary institutions for the care and training of educable mentally defective children were started in the mid-nineteenth century. The Royal Commission on the Blind, Deaf, and Dumb (1889) recommended special instruction for mentally defective children, and the Leicester and London School Boards established special day schools in 1892. By 1889 about forty centres for defectives and epileptics had been opened in different parts of the country. Report of the Mental Deficiency Committee, 1926, Part II, pp. 52–3.

Local Education Authorities the duty of ascertaining the numbers of mentally and physically defective or epileptic children in their areas, and of making special provisions for them. These provisions are extended, and in certain important respects modified, by the Education Act, 1944.

It is significant that in the relevant sections of this Act and its attendant regulations[1] the children to be dealt with as handicapped are described as 'pupils requiring special educational treatment' and it has been pointed out by the Chief School Medical Officer that this classification is fundamentally an educational one. Only in those cases where the handicap is of such a nature and degree as to prevent the child from benefiting from primary or secondary education alongside normal children is he to be given special treatment.[2] Even a relatively severe disability, such as the loss of a limb, does not necessarily mean that the child is regarded as 'handicapped', since it may not affect his ability to profit from an ordinary education. The Handicapped Pupils and School Health Service Regulations, 1945, lists eleven categories of children as within the scope of this definition—the blind, the partially sighted, the deaf, the partially deaf, the delicate, the diabetic, the educationally sub-normal, the epileptic, the maladjusted, the physically handicapped, and those with speech defects. Each of these categories of handicapped children needs a special and different adjustment of the educational system, and within each category there are wide differences between individual children. Special educational treatment is, in consequence, a branch of the education service making heavy demands on the skill, understanding, and patience of those teachers and administrators who undertake this responsibility.

The first task is that of selecting or 'ascertaining' those children in need of special treatment, and the Education Act, 1944, makes this a statutory duty of Local Education Authorities.[3] A child may be brought to the notice of the authority by his parents, who have the right to have him examined if he is over the age of two, even if at the time of the examination he is not attending school,[4] his teacher, the school medical officer, the school welfare officer, or a representative of an outside statutory or voluntary organisation

[1] Education Act, 1944, Sections 33 and 34; Handicapped Pupils and School Health Service Regulations, S.R. & O. 1945, No. 1076.

[2] *The Health of the School Child, 1939–45*, p. 98.

Cf. the definition of a disabled person given in the Disabled Persons (Employment) Act, 1944, where disablement is defined in relation to ability to obtain and hold employment in competition with normal persons. See below, Chapter XVIII.

[3] Education Act, 1944, Section 34 (1). [4] Ibid., Section 34 (2).

interested in his welfare, such as a hospital almoner.[1] On receipt of this information the authority will arrange for the child to have a medical examination. They must inform the parents of the time and place at which it is to be held, and, if necessary, serve them with a legal notice requiring them to submit the child for examination.[2] When he has examined the child the medical officer advises the parents and the Local Education Authority as to whether or not he considers the child is suffering from any disability of mind or body, and if so, the extent and nature of this disability, and the category of pupils requiring special educational treatment to which he belongs.[3] There the doctor's responsibility ends. Responsibility for determining the child's educational future rests with the Local Education Authority. In making its decision the authority gives due weight to the result of the medical examination, but may also take into account any information that it obtains from other sources, such as the child's teacher or an educational psychologist.[4] It must also consider the wishes of the child's parents, and if the parents are dissatisfied with the decision of the authority they may appeal to the Minister of Education, either denying that the child is suffering from a disability which makes special educational treatment desirable, or, while admitting that the child is suffering from a disability, denying the need for education in a special school.[5]

The special educational treatment the child requires may be given at a residential or day special school or in a normal school. Certain categories of children, the blind, the deaf, the epileptic, and the physically handicapped, must be educated in special schools, but arrangements for the others may be made inside ordinary schools, should this be considered necessary or desirable. In these cases the decision will depend on such factors as the severity of the defect, the accommodation available—which in its turn may

[1] 'Authorities should invite the co-operation of all such bodies in assisting them to make their ascertainment complete.' *The Health of the School Child, 1939–45*, p. 99.

[2] Ibid., Section 34 (1).

[3] The form of the prescribed certificate is given in the Handicapped Pupils (Certificate) Regulations, S.R. & O. 1945, No. 1302.

[4] *The Health of the School Child, 1939–45*, p. 99. This is one of the differences between procedure under the 1944 Act and that under the 1921 Act. Under the latter Act, if the medical officer signed a certificate of defect as a result of his medical examination, it was the duty of the Local Education Authority to find the child a place in a special school, i.e. the doctor settled the nature of the child's education. The realisation of the inappropriateness of giving this educational responsibility to a medical man led to the procedure being changed to that described above.

[5] Education Act, 1944, Sections 34 (6) and 37 (3). See also *The Health of the School Child, 1939–45*, p. 101, 'Appeals to the Minister'.

depend on the character of the area, since it is easier to provide an adequate number and variety of day special schools in large cities than in small towns or rural areas—or on the policy of the particular Local Education Authority, for there are differences of opinion and emphasis in these matters. On the one hand it can be argued that a handicapped child who, while he receives special educational treatment in the classroom, mixes with his normal school mates in the playground and shares their out-of-school activities as far as possible, receives a better preparation for adult life than the child segregated in a special school. On the other hand, however, a child treated in this way may develop a sense of social as well as educational inferiority, the results of which may be harmful.[1]

Similar social and psychological considerations have to be borne in mind when deciding on the desirability or otherwise of residential treatment, as Dr. J. D. Kershaw, School Medical Officer of Colchester, has pointed out. Residential treatment is essential for the proper training of certain categories of handicapped children, such as the blind, and necessitated by the medical needs of others, such as the cripple receiving treatment in an orthopaedic hospital, but in other groups its advantages have to be weighed against the harm which may be done by uprooting the child from the social setting in which he has grown up and to which he may have to return, a comparative stranger, when school days are over. Hence, where there is any choice, the decision to send a child to a residential special school should only be reached 'after careful weighing of all these considerations as they apply to each individual child, always with the view to the secure establishment of the child in society'.[2]

The largest, and in some ways the most difficult, group of children for whom special educational treatment is required are the children described as educationally sub-normal, and defined as 'pupils who, by reason of limited ability or other conditions resulting in educational retardation, require some specialised form of education wholly or partly in substitution for the education normally given in ordinary schools'.[3] This definition brings together

[1] *The Health of the School Child*, 1952–3. Chapter VIII is a strong plea for retaining handicapped children in ordinary schools wherever possible.

[2] Dr. J. Kershaw in the Practitioner Handbooks, *Child Health*, ed. Alan Moncrieff and W. A. R. Thomson, pp. 86–90. For further information about the treatment of handicapped children see Ministry of Education Pamphlet No. 5, *Special Educational Treatment*, H.M.S.O., 1946. Also *The Health of the School Child, 1946–7*, Sections VIII (Epilepsy), IX (Cerebral Palsy), XI (Partially Sighted Children), and XII (Hospital Schools).

[3] Ministry of Education, *Special Educational Treatment*, p. 7. The Ministry estimates that educationally sub-normal number 10 per cent of registered pupils. Approximately 2·0 per 1,000 are considered to be in need of residential education and a little less than 1 per cent in need of education in day special schools.

those children whose retardation is due to innate mental sub-normality, and those who are backward as a result of some other cause, such as irregular attendance whether due to ill-health or home circumstances, disharmony in the home leading to psychological maladjustment; or some other quite simple cause such as insufficient sleep. This is a major change in policy, as under the Education Act, 1921, a child had to be certified as mentally defective within the meaning of that Act before he could be educated in a special school,[1] and is in accordance with the recommendations of the Joint Committee of the Board of Education and the Board of Control which examined the problem between 1924 and 1929.[2] The Ministry recognises the importance of ascertaining the cause or combination of causes of the child's retardation as soon as may be, since this will influence the kind of educational treatment given, but it is no longer necessary to await a decision on this issue before commencing treatment, and indeed observations of its effects may throw light on the cause of the trouble.[3]

Like other handicapped children those who are educationally sub-normal may be educated either in residential or day special schools or receive special teaching inside a school for normal children, and as with other categories, social and temperamental factors as well as the degree of disability must be taken into account when deciding on the precise nature of the treatment. Residential special schools take the most difficult as well as the very backward children, but there is a serious shortage of such accommodation, and pupils in need of such treatment may have to wait some time before it is available. The local authority's difficulties are increased when they become responsible for those young delinquents found by the juvenile court to be educationally sub-normal and committed to their care instead of being sent to an approved school. Vacancies in residential schools must be found for such cases as quickly as possible, and this means a longer waiting period for children who have not offended against the law, but whose need for residential educational treatment may be almost equally urgent. Moreover, the presence of delinquents in a special school may be harmful to the non-delinquents, and in any case prejudices the school in the eyes of parents. The provision of adequate

---

Provision of day special schools to this extent is only practicable in large urban areas, however. Ministry of Education, *Special Educational Treatment*, footnote to p. 11, pars. 57 and 59, pp. 21–2.

[1] Education Act, 1921, Section 55.

[2] The Report of the Mental Deficiency Committee, Part II, 'The Mentally Defective Child', 1929, pp. 116–119

[3] *Special Educational Treatment*, par. 48, p. 19.

accommodation for educationally sub-normal delinquents is an urgent need.[1]

Day special schools provide the necessary special education for those whose ability is seriously limited,[2] but do not need residential training and care. They were first established by the London and Leicester School Boards in 1892, and their numbers increased after the passing of the Elementary Education (Defective and Epileptic Children) Act in 1899. In January 1948 there were 113 day special schools for the educationally sub-normal accommodating in all more than 10,000 children. Much admirable work is done in these schools which aim at encouraging the child to develop such abilities and skills as he possesses to the utmost, and to grow in self-respect, self-confidence and self-control.[3] Experimental work done in them has not only benefited the children immediately concerned, but influenced the nature and content of the teaching given in schools for normal children.[4]

Day special schools, valuable as they are, are not the most appropriate form of educational treatment for all educationally sub-normal children. Many, particularly the less seriously retarded, may do better if taught in special groups or classes in the ordinary primary and secondary schools, where they can mix with other children in the playground and join in general school activities. Moreover, in rural areas, the establishment of day special schools is impracticable, and here all children who are not sent away for residential treatment, will have to be catered for in the primary and secondary schools in the area.

While too rigid demarcation is undesirable, it is generally recognised that a child whose I.Q. is less than 50–60 is probably ineducable even in a special school, and the Education Act lays it down[5] that such children shall be referred by the Local Education Authority to the Local Health Authority. In deciding whether or not a child should be so referred the education authority must take into account not only his capacity for benefiting from the education it provides, but also the expediency of attempting to educate

[1] This question was raised on the adjournment and debated in the House of Commons, 2nd May 1951. The Parliamentary Secretary to the Ministry of Education was against the too rigid segregation of such children. Parliamentary Debates (*Hansard*), Vol. CCCCLXXXVII, No. 100, cols. 1,389–96.

[2] The Ministry of Education suggest that these schools are appropriate for children with an I.Q. range of about fifty-five to seventy or seventy-five, but suggests that other factors such as emotional stability and home conditions should be taken into account, particularly in deciding whether those with rather higher intelligence should be sent to special schools. *Special Educational Treatment*, pars. 38–61, pp. 21–2.

[3] Report of the Mental Deficiency Committee, Part II, 'The Mentally Defective Child', p. 55.

[4] Ibid., p. 54.

[5] Section 57.

him in association with other children 'either in his own interest or theirs'.[1] When once the child has been found to be ineducable, and this fact has been reported to the Local Health Authority, the latter becomes responsible for his training and care. In appropriate cases arrangements may be made to place him in a colony or other institution for mental defectives,[2] but there is a serious shortage of places in such institutions. This shortage is of long standing. It was commented on by the Wood Committee in 1929,[3] and the Curtis Committee, reporting in 1946, returned to the charge, saying, 'We understand that the knowledge that there is no room in the mental deficiency institutions and residential schools results in the children not even being referred to the appropriate authorities'. Unfortunately, with present shortages and economic stringencies there is little likelihood of any substantial improvement in the near future, but in planning for the more fortunate children and those whose care is apparently more rewarding, provision for these most grievously handicapped of all children should not be overlooked, as without proper care and training they may deteriorate, and bring acute anxiety and unhappiness to their parents and other members of their families.

Should transfer to an institution be considered unnecessary, or no place in one be available, the defective child will remain at home under the supervision of the Local Health Authority, and it is one of the duties of this authority to provide suitable occupation or training for him.[5] This is best given at an occupation centre, but if this is not possible, for example, in the case of a child living in an isolated area, it may be provided by means of home teaching. Occupation centres give simple habit and social training designed to develop the children's minds and bodies within the limits of their defect, and help them to learn to live happily in association with others both at the centre and, even more important, in their own homes. Advice and assistance are also given to parents, who are encouraged to continue the training at home. Thus, in time, the defective children learn to take part in family life, and are re-

[1] The Ministry appears to consider that in deciding whether or not a particular child shall be notified to the local health authority as ineducable, too little attention is paid to the interests of the other children associating with him, and suggests that school medical officers should be more ruthless in the discharge of these duties. *Special Educational Treatment*, par. 52, p. 20. *The Health of the School Child, 1939–45*, p. 102.

[2] These institutions are described in Chapter XIX.

[3] Report of the Mental Deficiency Committee Part II, par. 76, p. 69.

[4] Report of the Care of Children Committee, par. 509, p. 176.

[5] Mental Deficiency Act, 1913, Section 30, as amended by the Mental Deficiency Act, 1927, Section 7. Plans for training defectives at home or in occupation centres had to be included in the schemes submitted to the Minister under Section 51 of the National Health Service Act.

garded as persons 'instead of afflicted beings from whom nothing is expected and for whom all that is needed is protection and shielding'.[1] Occupation centres thus provide valuable help for both defective children and their families, but, as with so many other desirable and useful institutions, there are far too few of them to meet the need, and the spectacle of an unhappy imbecile child, for whom there is no room at the occupation centre, hanging about the gates of the school from which he has been excluded, is not unknown. Part of the shortage is a shortage of personnel to staff the centres, and the National Association of Mental Health has organised a training course to help meet this need.

Until comparatively recently the maladjusted child was the type of handicapped child who received the least understanding and sympathy, since his maladjustment frequently manifested itself in ways which led him to be regarded as a naughty child in need of punishment rather than a sick child in need of treatment, and even when physical symptoms such as enuresis were present, these were liable to be misunderstood and wrongly treated. The first child guidance clinic, the clinic founded by William Healy in Chicago in 1909, and known for many years as the Juvenile Psychopathic Institute, was an attempt to deal with delinquency in childhood, and was associated with the Chicago Juvenile Court. As time went on, however, it was realised that methods used in connection with young delinquents could also be applied to other difficult or disturbed children, and child guidance clinics dealing with all forms of emotional disturbance in childhood were established first in U.S.A. and later in this country.

From their early days a characteristic feature of child guidance clinics has been their team work.[2] In a clinic run on classical lines the team consists of a psychiatrist, an educational psychologist and a psychiatric social worker. Although there are variations in the pattern, the psychiatrist usually seeks to understand the child's emotional difficulties and conflicts, and helps him to deal with them; the psychologist tests his intellectual capacity and educational attainments, and where necessary and possible helps him overcome any special scholastic difficulties and deficiencies; while the psychiatric social worker is primarily concerned to assess and, if necessary, modify the social factors in his environment affecting his behaviour, so that a happier adjustment may be made. The

[1] National Association for Mental Health, *Occupation Centres for Mentally Defective Children*, 1948, p. 11. The description of the aims and working of an occupation centre given above is based on this pamphlet and the Report of the Mental Deficiency Committee, pp. 67–9.

[2] For a useful description of the organisation and work of a child guidance clinic, see *An Introduction to Child Guidance*, by W. M. Burbury, E. M. Balint, and B. J. Yapp, 1947.

importance of play as a means of self-realisation and an aid to diagnosis and treatment is widely recognised, and opportunities for the child to express himself in this way, either individually or as a member of a group, are provided in all clinics. In some, play therapists have been appointed.

Thorough diagnosis and treatment in a child guidance clinic is a long, elaborate and expensive process. Consequently in some of the cases referred, especially if the clinic serves a wide area, diagnosis alone can be given, and the worker referring the case is advised as to treatment, but left to carry it out himself, a state of affairs which accentuates the need for a deeper understanding of the principles of mental health on the part of educationists, and health and social workers. Moreover, probably many of the children brought to child guidance clinics need never have become sufficiently disturbed as to need psychiatric treatment had their parents, teachers and others in contact with them understood how to help them make satisfactory adjustments at different stages of growth, and had known how to satisfy their emotional as well as their physical needs. Help in achieving this understanding can be given to parents through such agencies as infant welfare centres and parent-teacher associations, and in some areas psychiatric social workers are already taking part in this preventive work.[1]

Pioneer work in the establishment of child guidance clinics in this country was undertaken by voluntary organisations, the first in the field being the Jewish Health Organisation which started the East London Child Guidance Clinic in 1927, but, as the value of the work became more widely recognised, certain Local Education Authorities established clinics of their own, and others grant-aided clinics run by voluntary organisations. The uprooting of

[1] See, for example, D. M. Hutchinson, 'Clinic and Community: The Psychiatric Social Worker's Role in Preventive Child Guidance Work', and Betty Joseph, 'A Psychiatric Social Worker in a Maternity and Child Welfare Centre'. Both of these articles are to be found in the *British Journal of Psychiatric Social Work*, August 1948. Also compare the above paragraph with the following quotation from a speech made by Professor McCalman, Department of Psychiatry, University of Leeds, at the Eighth Inter-Clinic Child Guidance Conference, 3rd December 1949. 'The orthodox child guidance team is an expensive instrument which must be used to the best advantage. I have always felt that it should be used in a consultant capacity, and called in to help in the diagnosis and treatment of unusual and difficult cases. In the process of dealing with such cases the clinic should, indirectly, educate a number of persons and agencies in the community and they, in turn, should be better able to deal with the less pathological cases along the same lines. Methods should gradually be evolved whereby the clinic could safely act as a consultant agency to probation officers, teachers, doctors, health visitors, parents, etc., who might in time be regarded as the general practitioners in the field of mental hygiene. This in turn would free the clinic to tackle the very type of case for which it was originally designed.'

children from their homes and neighbourhoods and the general disruption of family life which resulted from the Second World War led to a good deal of psychological disturbance among children, and accentuated the need for the provision of more child guidance facilities, but progress was hindered by an acute shortage of skilled personnel of all kinds. In spite of these difficulties progress was made even during the war, and by 1945 the total number of clinics had risen to 79, of which 57 were wholly and 6 partly maintained by Local Education Authorities.

The importance of tackling the problem of the maladjusted child was recognised by the inclusion of this group of children among those for whom special educational treatment must be provided under the Education Act, 1944. In making its plans for helping these children the Ministry assumed that many of them could be dealt with satisfactorily by an educational psychologist working in association with teachers and social workers, but it recognised that others would require psychiatric treatment. Hence the clinic under medical direction remained as an integral part of the school health service.[1]

The passage of the National Health Service Act was followed by the establishment of the principle that the Regional Hospital Boards would take over the responsibility for the consultative and specialist work undertaken in school clinics, while school medical inspection and the ascertainment of handicapped pupils would remain a responsibility of the Local Education Authority.[2] The child guidance service, which combined social and educational work with specialist treatment, presented a particular problem. The solution suggested by the Ministry of Education was that Local Education Authorities should provide a psychological service including child guidance centres operated by teams of workers, each team to include a psychiatrist and, as a rule, a paediatrician. The functions of the service were intended to be mainly diagnostic and educational, and to cover the ascertainment of maladjusted pupils for whom special educational treatment was required. Children who required psychiatric treatment for serious maladjustment were to be referred to the child psychiatric clinics being established by the Regional Hospital Boards. It would appear, however, that final responsibility for providing a child guidance service remains with the Local Education Authority, since if they find that the need for specialist treatment is not being wholly met in any other way, they are expected to take action.[3] These proposals have caused a certain amount of disquiet among child guidance workers, who were concerned lest this administra-

[1] *The Health of the School Child, 1939–45*, pp. 68–9.
[2] Ministry of Education Circular 179. [3] Ibid., pars. 18–20.

tive set-up would lead to a dichotomy between the education service and the service under the Regional Hospital Board which would result in the separation of diagnosis from treatment, and the splitting of the child guidance team.[1] It is too soon yet to say how far these fears are justified, but whatever the pattern which emerges, close co-operation at all levels would seem to be essential if the effectiveness of the work is to be maintained and extended.

The child guidance clinic is the most potent factor in dealing with the problem of maladjustment in children, but its work is hampered unless other provisions are made for their treatment. Among the most important of these are the hostels and boarding-schools for the more seriously maladjusted who need residential treatment at least for a time, and the value of these was amply demonstrated during the war. Some authorities have also experimented successfully with special day schools. These have been of great help to 'children of unfulfilled promise', that is, children whose intelligence is good, but whose educational attainments are below normal, possibly owing to some psychological maladjustment. With the co-operation of an educational psychologist or, if necessary, the whole child guidance team, much can be done to help these children to overcome their difficulties, and make the progress which their intellectual abilities warrant.

The child guidance service is thus a growing and developing one. Administratively the present position is rather confused and uncertain; serious staff shortages hinder expansion and there is much educational work to be done before magistrates, doctors, educationists and administrators fully appreciate the nature and value of the work undertaken. Nevertheless progress is being made in the establishment of clinics and centres, and the principles and attitudes on which the service is built are becoming more widely accepted.

So far in this and the preceding chapter we have been mainly concerned with the development of statutory provisions to further the health and well-being of the children of the nation, but this is a field in which voluntary effort has also played a prominent part. Voluntary organisations have pioneered in all the forms of child care discussed, from child guidance clinics to school meals. One of the services which has continued to the present day is social case work with crippled or invalid children. This still forms the basis of the work of the Invalid Children's Aid Association which was founded in 1888 by a C.O.S. worker (Mr. Allen Graham), who was moved by the unhappy and restricted lives of crippled children

[1] Abbreviated Report, Eighth Inter-Clinic Child Guidance Conference, London, December 1949. Published as a supplement to *Mental Health*, Vol. IX, No. 3.

living in poverty-stricken and overcrowded homes at the mercy of ignorant even if well-meaning and affectionate parents to devise plans for providing companionship for the children and advice to the parents. The association was an offshoot of the Charity Organisation Society, and strongly imbued with C.O.S. ideas, but it was soon realised that friendly visiting and case work on C.O.S. lines were by themselves totally inadequate to meet the needs of the invalid child. Unable to content itself with visitation 'where the conditions of the home are such that a legion of visitors would be powerless to effect substantial good'[1] the association launched out into big schemes of child welfare work, including hospital and convalescent care, and the provision of milk, tonics, and orthopaedic apparatus. The more efficient of the provincial associations founded on the same lines were similarly enterprising,[2] often working in close co-operation with the developing statutory services, by whom they were grant-aided. The greater powers conferred on statutory authorities by the Education Act, 1944, and the National Health Service Act, 1946, have curtailed the activities of these voluntary associations in some directions, for example, by enabling local authorities or Regional Hospital Boards to take over children's hospitals or residential special schools formerly maintained by them. Certain forms of child care, however, such as short-term or preventive convalescent treatment, and hospital after-care, where the supervision required is social rather than medical, still remain in their hands, and there is still pioneer work outside the scope of the authorities to be done, as, for example, the provision of convalescent holidays for mothers and young children, which is one of the activities of the Liverpool Child Welfare Association. At the same time such organisations can only survive if they maintain close co-operation with the statutory authorities and can show that they have a real contribution to make to the welfare of the child which cannot equally well be made by one of the branches of the health or education services.

[1] Extract from an early Annual Report.

[2] As for example, the Liverpool Invalid Children's Aid Association, which owing largely to the energy and initiative of Margaret Beavan grew into one of the largest and most progressive associations in the country. In 1918 it changed its name to the Liverpool Child Welfare Association to express the idea that it was concerned with healthy as well as with invalid children, with prevention as well as treatment. Ivy A. Ireland, *Margaret Beavan of Liverpool*, p. 90.

CHAPTER XIII

THE CHILD DEPRIVED OF HOME CARE

'Without affection, life has little meaning for most people and none at all for children.'—RICHARD M. TITMUSS.

PSYCHOLOGISTS tell us that a happy family life in which the child both gives and receives affection, feels secure, and has his own accepted status and significance, is the most important of his needs, more important even than a high standard of physical care, and recent studies of delinquency among young people[1] have emphasised the serious effects which separation from his family, real or believed rejection by it, or embittered relations within it, may have on his mental and emotional development. Consequently the community has a special responsibility for seeing that those children who have no homes, or for some reason cannot be allowed to remain in their own homes, receive imaginative and loving alternative care.

Such children may be divided into four main groups. In the first place there are those whose deprivation is only temporary, resulting from some such cause as the mother's illness; secondly those who have no homes—the orphans, deserted and destitute; thirdly those who are removed from their homes either because of their own misbehaviour or because home conditions are so detrimental to their moral and physical development that they cannot remain in it; and fourthly there are those children who are suffering from a mental or physical handicap which necessitates institutional care.[2] Many children are deprived of home care by circumstances beyond human control, and all that can be done is to help them to build their lives afresh in as homelike surroundings as possible. There are others, however, particularly among those taken from

[1] E.g., D. H. Stott, *Delinquency and Human Nature*, Carnegie U.K. Trust, 1950. See also J. Bowlby, *Maternal Care and Mental Health*. This important monograph was not available at the time of writing.

[2] The Report of the Care of Children Committee, 1946, emphasises this point in paragraph 7, which reads, 'The consideration of the welfare of children deprived of home life inevitably raised in our minds and those of many of our witnesses the question whether this deprivation might not have been prevented. This is a question we regard as of the utmost importance and we hope that serious consideration will be given to it. . . .'

their homes because of neglect, ill-treatment, lack of control or moral danger, whose deprivation might perhaps have been prevented, and the community's responsibility for taking steps to prevent the deterioration of family life which ends in this deprivation is being increasingly realised.

If this problem is to be tackled effectively further research into the social and psychological conditions underlying the neglect or ill-treatment of children by their parents as well as administrative action is needed. A pioneer study of this nature was undertaken in 1946–7 by the Women's Group on Public Welfare, and its results were published under the title of *The Neglected Child and His Family*. It was based partly on the evidence of expert witnesses such as doctors, health visitors and social workers and partly on the result of three special investigations; one into the background of a sample of 234 children selected at random from among the 2,000 admitted to Dr. Barnardo's Homes between January 1937 and January 1940; the second into the incidence of child neglect among 2,000 widows in receipt of supplementary pensions from the Assistance Board; and the third a case study of a small group of women committed to Holloway Prison for child neglect during 1946.

As a result of its investigations the Women's Group on Public Welfare concluded that cruelty, or deliberate physical ill-treatment, formed only a small part of the whole problem, and would seem to be mainly the outcome of abnormal psychology, but that neglect or failure to make adequate provision for the physical, emotional and intellectual needs of the child, is much more frequent and has wider social implications. It cannot be ascribed to any one cause, but like other social problems it arises from the interplay of a great number of factors, physical, psychological and economic, which, together, bring about a strain too great to be borne. 'Poverty, ignorance, bad housing, marital disharmony, excessive child-bearing, all these play a part', and 'We are left with the impression not of wilful, cruel, reprehensible mothers (though these do exist), but of women struggling with inadequate equipment, mental and material, to deal with problems which would tax even those highly endowed'. 'In many cases, had the mother been of higher mentality, she might have surmounted the difficulties. Had the difficulties not been so complex her mental inadequacy would not have had such disastrous effects. The cycle is difficult to break; mismanagement—poverty—malnutrition—ill-health—apathy.'[1]

This diagnosis of the situation corresponds very closely with the accounts given by social workers and investigators of the factors

[1] Op. cit., pp. 71 and 23.

contributing to the creation of problem families[1] and the two problems are closely associated, although not coincident. Child neglect is frequently found in problem families and is both a symptom and a result of the general collapse of morale which characterises this particular social group, and in these cases it cannot be treated as an isolated phenomenon. Instead an effort must be made to rehabilitate the family as a whole, and this is recognised in a circular *Children Neglected or Ill-treated in Their Own Homes*, recently issued jointly by the Home Office, Ministry of Health and Ministry of Education.[2] The circular, which is based on the recommendations of a Working Party composed of officials of the three departments, states explicitly that 'the Ministers are convinced that it is by means of improved co-ordination that this complex problem can best be dealt with', and the circular suggests to the Councils of Counties and County Boroughs that co-operation might be achieved by designating an officer who will be responsible for 'enlisting the interest of those concerned and devising arrangements to secure full co-operation among all the local services, statutory and voluntary, which are concerned with the welfare of children in their own homes'. This officer is expected to hold regular meetings of statutory officials and representatives of voluntary organisations, and to arrange for 'significant cases of child neglect and all cases of ill-treatment' coming to the notice of any statutory or voluntary service in the area to be reported to him with a view to its discussion at one of these meetings 'so that, *after considering the needs of the family as a whole*[3] agreement might be reached as to how the local services could best be applied to meet these needs'.

It is too early as yet to pass any comment on the working out in practice of these proposals, or the difficulties which may be encountered in their implementation.[4] They are significant, first because they indicate a definite acceptance by the State of its responsibility for tackling child neglect in its early stages, and by means other than the use of its coercive powers, secondly, because they are directed towards the rehabilitation of the family as a whole, and not simply to the protection of the neglected child; and thirdly, because they provide the means whereby local authorities may take the initiative in promoting co-operation between the different organisations, statutory and voluntary, concerned in their

[1] See above, Chapter IX.

[2] Circular 157/50 Home Office; 78/50 Ministry of Health; 225/50 Ministry of Education, 31st July 1950.

[3] Italics mine.

[4] Co-operation between the different services (including the work of a co-ordinating committee) is discussed in D. V. Donnison, *The Neglected Child and the Social Services*, Manchester University Press, 1954.

different ways to further the well-being of individuals and families in their areas. They have, therefore, considerable possibilities and it will be interesting to see how far these are realised.[1]

While measures aimed at the prevention or remedy of child neglect should be directed towards the family as a whole, yet the key to the situation is likely to be held by the mother. 'The father may be the head of the family but the mother is its heart, and where families have broken down it is largely because of the failure of the mother.'[2] As we have seen, such failure is generally the outcome of the interaction of a number of causes among which ill-health, poor mental endowment, ignorance and the influence of an unsatisfactory physical environment are usually prominent, and it has been found that such a mother is likely to benefit greatly, and may even find sufficient strength and courage to tackle her difficulties instead of succumbing to them, if she can get away from her home for a period of refreshment and rehabilitation at a well-run recuperation centre. It is important, however, that she should take her youngest child or children with her, partly because she is likely to settle down better if they are there also, partly because it should never be suggested to the mother that her children are a drawback to her happiness, and thirdly because the aim of such recuperation is not simply to restore the mother to health, but to help and encourage her to become a more efficient mother. Education in child care is thus an important part of the work of a centre.[3]

Recuperation centres for mothers and young children are unfortunately few and far between, and, as they are difficult and expensive to maintain, their numbers are unlikely to increase much in the near future. One of the most successful is Brentwood, Marple, Cheshire, a centre where mothers recommended by local authorities or voluntary organisations as in need of rest and recuperation because their health has suffered by too frequent pregnancies, illness, poverty or other hardships, may go with their children under seven. While not primarily intended for problem mothers it has proved particularly successful with them, and it has been found that they benefit from mixing with others who, faced with equal if not greater difficulties, have maintained their self-respect and morale. This learning from their fellows is but one of the means by which the problem mothers are helped to discover and apply higher standards of home and child care. They help in the

[1] The Sixth Report on the Work of the Children's Department, published by the Home Office in May 1951, indicates that the response made to Circular 157 by local authorities and voluntary organisations has so far been encouraging. Pars. 162–3, pp. 40–1.

[2] Alison Pope, 'Investigation into the Problem of the Tired Mother', *Social Welfare*, Vol. VII, No. 6, April 1949, p. 139.

[3] Pope, op. cit., p. 145.

house, assist in preparing the meals, attend simple cookery and needlework demonstrations, observe the methods used by the helper in charge of the nursery where their toddlers are cared for during the day, and attend the local clinic—for all these activities form part of the accepted manner of life at the centre, and, without realising it, they are slowly being taught the skills essential to the maintenance of a happy and well-ordered home life. Meanwhile, good food, adequate rest and country air are helping to build them up physically, and social activities not only encourage them to take pride in their personal appearance—perhaps the first sign of a dawning self-respect—but help to give them something of the joy in life of which so many have been robbed by monotonous years in drab and squalid surroundings.

The majority of women who go to Brentwood are referred there by voluntary organisations or the local health authorities, and they go there of their own free will, but there appears to be no essential difference between many of these mothers and those who have been brought before the courts and convicted of neglect.[1] Imprisonment is a thoroughly unconstructive way of dealing with such cases, and may cause intense suffering not only to the neglectful mother but also to her young children, since, in spite of all appearances to the contrary, mothers and children in such cases are often genuinely fond of each other. Re-education at a home run on the lines of Brentwood would seem to be much more hopeful as well as a more humane method of treating such neglectful mothers. A small experimental home for mothers convicted of child neglect, which has accommodation for nine mothers and eighteen children, has recently been opened at Plymouth under the auspices of the Salvation Army, and neglectful mothers can be put on probation with a condition attached that they reside at the home for four months with their children under five as an alternative to being sent to prison. The Probation Branch of the Home Office pays the Army on a *per capita* basis for the mothers, while the expenses of the children are met by the local authorities, who would probably have had to maintain them in their own homes if the alternative sentence of imprisonment had been imposed.

Residential treatment of the kind described is a very valuable means of helping mothers who, finding their burdens too heavy, refuse to shoulder them, but it has its limitations. Unless a case work organisation such as the Family Service Units has been tackling the home situation in her absence, the mother is likely to come back to conditions as bad as, if not worse than, those she left when she went away. Further, unless she is given continued active

[1] The twelve case studies analysed in *The Neglected Child and His Family*, pp. 24–32, illustrate this point.

support and encouragement at this stage her new-found courage and energy may give way under the renewed strain, her good resolutions and newly acquired skills be forgotten, and she may all too easily slip back into her old slovenliness and apathy. Thus, if it is to be effective, residential treatment should not be regarded as a complete answer to the problem of the neglectful mother, but as the more intensive and central part of a much more prolonged process, beginning with the thorough understanding of the case by the social worker, and ending with a long period of after-care, during which improvements begun while the mother was away be consolidated.[1]

If all attempts to rehabilitate the family fail, and the situation deteriorates to such an extent that the children are suffering serious harm physically or psychologically because of their parents' indifference, neglect or active ill-will, then the State must step in to protect them, even if this means removing them from home. The State won its powers to do this with considerable difficulty, for they constitute a direct limitation of the parental rights. What was at stake in the struggle was the child's claim to be regarded as a person with rights of his own, which even his parents could not override, and which the community would defend if necessary. Only after a long struggle was such a claim established. 'If it had been a dog I could help you, but it is only a child', said one magistrate about a case brought before him in the early days of the National Society for the Prevention of Cruelty to Children[2] and during the years that followed Dr. Barnardo, Benjamin Waugh, the founder of this society, and other pioneers, had to devote much of their energy to bringing about changes in the law so that 'the doctrine of parental rights should not be allowed any longer to be the doctrine of children's wrongs'.[3]

Two major landmarks in the history of child protection were the Children Act, 1908, and the Children and Young Persons Act, 1933. The latter Act, which is operative at the present day, not only contains provisions for the prosecution and sentence of those who have the custody of children and wilfully neglect or cruelly treat them, or commit specific offences against them,[4] but also empowers juvenile court magistrates to remove children or young

[1] Alison Pope, op. cit., p. 146. [2] Quoted in *The Life of Benjamin Waugh*, by Rosa Waugh, p. 146. [3] National Children's Home and Orphanage Annual Report for 1884. Quoted R. M. Wrong, 'The Welfare of Children', ch. iii in Bourdillon, *Voluntary Social Services in the Modern State*, p. 38.

[4] Children and Young Persons Act, 1933, Part I, 'Prevention of Cruelty and Exposure to Moral and Physical Danger'. A child within the meaning of the Act is a person under the age of fourteen years, a 'young person' is a person who has attained the age of fourteen years and is under the age of seventeen years, but Part I applies to persons under sixteen years.

persons 'in need of care or protection' from the custody of their parents or guardians and make alternative arrangements for them.[1] A child or young person 'in need of care or protection' was defined as one who 'having no parent or guardian or parents or guardians unfit to exercise care or guardianship or not exercising proper care or guardianship' was 'either falling into bad associations or exposed to moral danger or beyond control'. Children against whom offences under Part I of the Act had been committed or were members of the same household[2] were included, as were children of vagrants who were prevented from receiving a proper education. Far-reaching as these provisions were, compared with earlier legislation, they were still open to criticism as being ambiguous or inadequate. One source of difficulty was that to be punishable the cruelty or neglect must have been 'wilful', that is intentional, and, while it is easy to see the legal principle underlying the insertion of this word, its presence made it difficult for a court to remove a child from the custody of its parents even when it was obviously in its interests particularly if it was not in 'moral danger', and hence it was held that an offence under Section 1 of the Act must be proved before such action could be taken. [6]The Children and Young Persons (Amendment) Act which came into operation in 1952 has enlarged the definition of a child or young person in need of care or protection to include one who has no parent or guardian or a parent or guardian not exercising proper care or guardianship and is ill-treated or neglected in a manner likely to cause him unnecessary suffering or injury to health'. It is no longer necessary to prove the offence of wilful neglect or ill-treatment.[3]

Under the Act responsibility for bringing cases to court is divided between the N.S.P.C.C., the various departments of the local authority and the police. Prosecutions for neglect are commonly instituted by the N.S.P.C.C., although in some areas the Local Education Authority may be responsible for such action through its school attendance and welfare department. Since the implementation of the Children Act, Children's Officers and Departments have dealt with, the 'care or protection' cases and there is a feeling in some quarters that they should also assume responsibility for administering Part I of the 1933 Act.[4] If the proposals contained in the recent circular *Children Neglected or Ill-treated in their Own Homes* are implemented and local authorities designate officers to whom cases of child neglect or ill-treatment discovered by statutory or voluntary bodies in their

[1] Ibid., Sections 61 and 62. [2] Section 61 (1) 3.

[3] *Children and Young Persons (Amendment) Act*, 1952, Section I.

[4] British National Conference on Social Work, 1950. Report of the Commission on Child Welfare, *Social Patterns*, p. 50.

areas are reported, then these officers might be the appropriate persons to institute court proceedings if, after discussion with all concerned, they were found to be necessary. The circular refrains from any suggestion as to which official should be the designated officer, but about half the officers designated so far are Children's Officers, most of the others either Clerks of Councils or Medical Officers of Health, although some authorities have chosen the Chief Education Officer.[1]

Various measures may be taken by the juvenile court for dealing with children or young persons found to be 'in need of care or protection'. If it is decided to go on trying to preserve the unity of the family, and keep the child at home, the parents may be ordered to enter into a recognisance to exercise proper care, or the child may be placed under the supervision of a probation officer, but in many cases the time for such preventive measures is found to be past, and the child is taken away from the custody of his parents and either committed to the care of a 'fit person' or sent to an approved school. In such cases he becomes a 'child deprived of home care' in the strict sense of the term, one of the 125,000 or so of all categories for whom the community is responsible.

For many years after the death of Dr. Barnardo and other nineteenth-century pioneers the general public was not particularly concerned about the quality of care given to deprived children, assuming that they were being properly looked after by the public authorities or voluntary agencies responsible. In 1944, however, attention was drawn to the unsatisfactory conditions existing in many children's homes by Lady Allen of Hurtwood, who wrote a strong letter to the *Times* on the subject and followed it up by a pamphlet *Whose Children?* which gave examples of harsh unimaginative treatment, amounting in some cases to cruelty, mental if not physical. The following year the death of a child boarded out by a local authority, as a result of neglect and ill-treatment, which could have been prevented had there been proper selection and supervision of the foster home[2] aroused the public from its complacency. In March 1945 an Inter-departmental Committee was appointed under the chairmanship of Miss (now Dame) Myra Curtis, 'to inquire into existing methods of providing for children who, through loss of parents or from any other cause whatever, are deprived of a normal home life with their own parents or relatives, and to consider what further measures should be taken to ensure that these children are brought up under conditions best

[1] Home Office, Sixth Report on the Work of the Children's Department, May 1951, p. 40.

[2] Dennis O'Neill. Report by Sir Walter Monckton, K.C.M.G., K.C.V.O., K.C., Cmd. 6636, 1945.

calculated to compensate them for the lack of parental care'. The Committee issued its report in September 1946.[1] As the result of a comprehensive survey covering all types of care of the deprived child in different parts of England and Wales[2] it concluded that 'while much good work is being done the standard is so variable and at the lower levels so poor that a determined effort must be made to lift the whole treatment of the child without a home to a new, more even and higher level'.[3]

Two major changes were required to bring about this improvement. In the first place the administrative machinery needed a thorough overhaul. Responsibility was divided between a number of central government departments and local authority committees, not to speak of the numerous voluntary organisations, and this resulted in confusion, overlapping and inconsistency of treatment. In order to obviate this the Committee recommended that responsibility for the care of all deprived children should be concentrated, both centrally and locally. One government department should be made responsible for the oversight of all forms of care of the deprived child, its function being to 'define and maintain standards by inspection, advice and direction',[4] while at the local authority level County and County Borough Councils should appoint *ad hoc* committees which would be responsible for the provision and maintenance of children's homes, for boarding out, for child life protection, for the local authorities' function with regard to adoption and for the keeping of records of all deprived children in their respective areas including those in voluntary homes. In order to carry out this work effectively each Children's Committee should appoint 'an executive officer of high standing and qualifications who would be a specialist in child care'.

These administrative recommendations were accepted by the Government and given legislative sanction by the Children Act, 1948. The Home Office was chosen as the central government department responsible for the care of deprived children and Advisory Councils in Child Care, one for England and Wales and one for Scotland, were appointed to advise the Secretary of State on his duties in this regard. Each County Council and County Borough Council was required to appoint a Children's Committee unless the Secretary of State was satisfied that owing to special circumstances the authority could best discharge its functions other-

[1] Report of the Care of Children Committee, H.M.S.O., Cmd. 6922/46.

[2] A separate enquiry was conducted and report issued by a Committee appointed by the Scottish Home Department, *Report of the Committee on. Homeless Children*, Cmd. 6911/46. The Chairman was Mr. J. L. Clyde, K.C. The findings and recommendations of the two committees are strikingly similar.

[3] Op. cit., par. 428. [4] Summary of Recommendations, par. 5, p. 178.

wise,[1] and each Children's Committee must appoint a Children's Officer, the appointment being subject to the approval of the Secretary of State.[2]

In addition to bringing at least a semblance of order out of administrative chaos the Act deals with various other legal and technical questions. It defines the responsibilities of the local authority, making it a duty for it to receive into its care orphans, deserted children and children whose parents or guardians are temporarily or permanently prevented from providing for their proper accommodation, maintenance and upbringing, provided such intervention is necessary in the interests of the child.[3] It also makes the Children's Committee and Officer responsible for the supervision of children under eighteen maintained apart from their parents for reward,[4] and further makes it a duty of local authorities to undertake the care of children committed to them by juvenile courts in accordance with the terms of Section 76 (1) of the Children and Young Persons Act. The Act provides that children or young persons in need of care or protection, or young delinquents, may be committed by the court to the care of 'fit persons' who then become responsible for their welfare. Hitherto local authorities had not been forced to take on 'fit person' responsibility against their wish, but now they are unable to evade it.

The provisions of the Children Act establish an administrative framework within which a comprehensive service for the care of children who have not the benefit of a normal home life can be developed, but administrative efficiency, essential as it is, does not in itself ensure the well-being of the child. Much more is needed, especially sensitiveness to the child's emotional needs, and the wisdom and loving kindness which alone can help heal the wounds caused by the loss of his home and family, perhaps under circumstances likely to cause the maximum damage to his personality. This is the crux of the matter, and this is where the Curtis Committee felt that the child care organisations were so often failing. It paid tribute to the physical care given to the children in the institutions visited, and recognised that this often reached a higher standard than the child would receive in his own home, but it noted that even where the institution was well managed there was frequently 'a lack of interest in the child as an individual and too

[1] Local Authorities may also combine to form Joint Committees for the purposes of this Act, Section 39 (4).

[2] Children Act, 1948, Sections 38, 39 and 40.

[3] Ibid., Part I, Section I (i). Section II allows the local authority to assume parental rights over the child in certain circumstances and subject to the right of appeal by the parent or guardian.

[4] This is generally known as Child Life Protection.

remote and impersonal relations'.[1] The second major improvement required was then to bring about as high standards as possible in the personal and psychological as well as the physical care of deprived children.

In order to provide for the right treatment of each individual child various forms of care should be available. Arrangements should also be made for each child likely to be in need of long-term care to spend a short period in an observation or reception home where he can be observed by trained and understanding workers, and medical and psychological examinations made if necessary, so as to ensure that, as far as possible, his first placing in a long-stay institution or foster home will be successful. The Children Act lays it down[2] that each local authority shall provide at least one home in its area for the temporary reception and observation of children, and the Home Office has issued a memorandum to local authorities which sets out its views on the staffing equipment and organisation of such centres.[3]

The two main forms of permanent care available for the deprived child are boarding out and institutional care. The former is generally preferred as it means that the child enjoys something more nearly approaching a normal home, and the Children Act lays it down that this should be the form of care given the child unless this is not practical or desirable for the time being.[4] It is not suitable in all cases however. Handicapped children needing special medical care and educational training must be catered for in institutions especially adapted to their needs and the young delinquent may require the discipline of an approved school, while the child who is seriously maladjusted as the result of his early experiences may need skilled treatment in a special hostel before he is boarded out. As Miss D. M. Dyson writes as the result of long experience: 'Neither form of care [i.e. in an institution or with foster parents] is in itself better or worse than the other, though either may be better or worse for the individual child. . . . The touchstone is not the excellence of the Home care over Foster Home care or vice versa, but in the choice for each of that form

[1] Report of the Care of Children Committee, par. 477, p. 160. But compare G. V. Holmes' tribute to the loving, personal care given her by her cottage 'mother' in Dr. Barnardo's Girls' Village Home, *The Likes of Us*, 1948.

[2] Section 15 (2).

[3] Circulated 1949. Printed as Appendix III to the Sixth Report on the Work of the Children's Department. Hilda Lewis, *Deprived Children* (Nuffield Foundation, 1954) is a study of the work of the reception centre at Mersham, Kent.

[4] Section 13 (1). On 30th November 1949 the number of children in the care of local authorities who were boarded out was 19,271, representing 35 per cent of the children in care. Sixth Report of the Children's Department of the Home Office, p. 12.

of care which will best suit him.'[1] It is, however, most important that whichever form of care is chosen is of the best possible quality. Hence there is great need for both the careful selection and supervision of foster homes, and an improvement in the standards of much of the present institutional care. The chief need in connection with the latter is to make conditions as homelike as possible, by dividing the children into small groups,[2] each with its own 'mother' and, if possible, each accommodated in a separate cottage. It is also very desirable to integrate the life of the institution into the life of the local community, so that the children are not segregated but have as many contacts as possible with the outside world.

Most vital of all requirements, however, is that of recruiting and training the right kind of people to staff the homes and hostels and act as Children's Officers and their assistants. As Miss Clement Brown[3] puts it, 'In the last resort there can be no guarantee of a child's welfare, except in the quality of the human beings who care for him,' and the Curtis Committee attached so much importance to the recruitment and training of the resident staff—the people who have the day-to-day care of the children—that they issued an interim report on it.[4] The training of the administrative staff is dealt with in Appendix I of the main report. In accordance with its recommendation a Central Training Council in Child Care has now been established, social science departments in selected universities are conducting Child Care Courses intended more especially for the training of boarding-out officers and administrative staff, while courses for house-mothers and others in kindred positions have been organised by local authorities and voluntary organisations. In spite of these efforts there is still a grave shortage of trained staff, particularly for residential posts, and much more should be done to raise the status of this kind of work in the eyes of the public, and attract the right type of people to it.

Lastly there is the question of after-care. The responsibility of the local authority or voluntary organisation does not end when the child starts to earn his own living, indeed there may be as great a need for understanding and guidance during the difficult years of

[1] D. M. Dyson, *The Foster Home*, p. 13.

[2] The Curtis Committee recommends that these groups should not exceed twelve in number and that ages and sexes should be mixed. Eight is regarded as the ideal number, par. 485.

[3] Training Adviser, Central Training Council on Child Care. Cf. Report of the Scottish Committee on Homeless Children, Cmd. 6911, 1946, par. 112: 'No amount of legislation and no multiplication of regulations will solve the problem of compensating a deprived child for the loss of his home. It is essentially an individual problem depending for its solution in each case on the insight and experience of those actually dealing with the children.'

[4] *Training in Child Care.* Interim Report of the Care of Children Committee, Cmd. 6760/46.

adolescence, when the youngster is trying to find his feet in the adult world without the support of a family background, than when the child is still sheltered in a home or foster home. The Curtis Committee stresses that after-care should be a matter of deep concern, and, after commending the schemes developed by some voluntary organisations, recommends that young people going out into the world should be encouraged to keep in touch with the Children's Officer and to feel that they can turn to him for advice and help in any difficulty.[1] One of the major problems young people encounter is that of finding suitable accommodation within easy reach of their work, and the Children Act empowers local authorities to provide hostels for young people under the age of twenty-one. These hostels are to be available not only for young people under the care of the authority, but for other young workers in the area, a valuable provision, as it enables young people hitherto isolated from their contemporaries to mix freely with those who come from ordinary homes. This gives them a better chance of growing up into normal members of the community, which is the aim of all forms of care of deprived children.

[1] Op. cit., par. 504.

CHAPTER XIV

THE YOUTH EMPLOYMENT SERVICE

A MAJOR question, frequently raised when the aims of education are discussed, is that of the extent to which it should take cognisance of the type of work that boys and girls are likely to go in for when they leave school, and prepare them for it. Opinions differ on this issue, but it has long been recognised that the adolescent leaving school for work cannot be left to find his own way in the unfamiliar world of industry and employment, but should be assisted to find the niche in it for which he is best suited by aptitude and ability, and when he has found it be protected from exploitation and injury. Thus, the early years of the century, which, as we saw in Chapter XI, witnessed the gradual realisation by Local Education Authorities that their responsibilities extended beyond instruction to providing for the physical and social needs of the children in their care, also saw the beginnings of the youth employment service. Local Education Authorities began to advise school leavers as to choice of employment, setting up Bureaux for the purpose, and in 1910 this work was officially recognised by the Education (Choice of Employment) Act which empowered them to advise boys and girls under seventeen[1] as to the choice of a career.

Meanwhile, the passing of the Labour Exchanges Act, 1909, resulted in the establishment by the Board of Trade of employment exchanges, primarily for adults, but often including juvenile departments. Not surprisingly these parallel developments by Local Education Authorities and the Board of Trade resulted in confusion and overlapping, and this was increased by the extension of unemployment insurance to cover boys and girls over the age of sixteen by the Unemployment Insurance Act, 1920. In 1923, as the result of an enquiry into the whole question, Local Education Authorities were allowed to choose between administering the whole juvenile employment service, including unemployment insurance, in their respective areas, or leaving it entirely alone, in which case the Ministry of Labour, which by now had taken over

[1] The Education Act, 1918, raised this age limit to eighteen years, at which level it has remained.

the employment functions of the Board of Trade, would take full responsibility. Central government control remained divided between the Board of Education and the Ministry of Labour until 1927, when the Minister of Labour was put in charge and made responsible for supervising and paying grants to those Local Education Authorities (104 out of a possible 315) who had decided to exercise juvenile employment powers.

The dual system of local administration thus established continued without any further administrative changes until towards the end of the Second World War, when Mr. Ernest Bevin, who was then Minister of Labour, set up a Committee under the chairmanship of Sir Godfrey H. Ince 'to consider the measures necessary to establish a comprehensive Juvenile Employment Service . . . and to make suggestions for a practicable scheme'. The committee issued its Report in September 1945[1] and the changes in the administration of the service which it recommended were embodied in the Employment and Training Act, 1948.

These changes, although important, were not fundamental, since the Committee, while it was unanimous in its view that an administratively unified service was desirable, found itself unable to agree as to which of the two alternative methods of administration developed during the previous thirty-five years was in fact themore desirable on grounds of principle or expediency. This divergence of opinion was perhaps to be expected from the very nature of the service itself, since it has both educational and industrial aspects. It guides and sustains the adolescent in his passage from school to work, and hence, of necessity, belongs in some measure to each of these different worlds. The dual nature of the service has been emphasised as our knowledge of the scope and character of vocational guidance has increased, for it is now recognised that this is more than a series of tests and interviews taking place during the child's last term, or even his last year, at school, but a continuous process, possibly lasting several years, starting when his interest is first aroused in the question of his future work, and not complete until he is settled in congenial employment, with appropriate prospects of advancement.[2]

Consideration of these matters brings home the difficulty of devising machinery which will do justice to all aspects, educational and industrial, of youth employment work. In the event, the problem has been solved as far as central government machinery is concerned by the creation of the Central Youth Employment

[1] Ministry of Labour and National Service, Report of the Committee on the Juvenile Employment Service, H.M.S.O., 1945.

[2] J. W. Reeves and V. W. Wilson, *Vocational Guidance in Warrington*, National Institute of Industrial Psychology, 1949, p. 14.

Executive[1] staffed by officers of the Ministry of Labour, and the Education Departments of England and Wales and Scotland, and the Minister of Labour, who remains the responsible Minister, may delegate his youth employment functions to this body.[2] The committee is supported by a National Youth Employment Council, which consists of representatives of interested bodies such as local authorities, teachers, employers and workers, and whose function it is to advise the Minister on all questions affecting the service.[3]

Unification has thus been brought about centrally, but the dual system remains in the areas. After the passing of the Act each Local Education Authority had to decide afresh whether or not it wished to provide a youth employment service. If it did so decide, the scheme it operated had to be approved by the Minister and cover the whole of its area. Of the 181 Local Education Authorities in England and Wales faced with this choice 129 have decided to undertake this work.[4] In the remaining areas the service is administered by the Ministry of Labour through the local employment exchanges.

Whether the youth employment service be administered locally by the education authority or as part of the work of the employment exchange, its objects remain the same. They are to assist the adolescent first to choose, and then to find the type of employment best suited to his aptitudes and abilities, and see him happily settled in it. This involves as complete an assessment as possible of the young person's physical, mental and personality traits, and a comparable analysis of the aptitudes required by different occupations. While much of this work is in the experimental stage a good deal of progress has been made in both types of investigation, and

[1] Until the passing of the Employment and Training Act the service was known as the Juvenile Employment Service, and the word 'juvenile' always used in connection with it. The Act substituted the word 'youth'.

[2] Employment and Training Act, Section 7 (1).

[3] Section 8 and First Schedule. A National Juvenile Employment Council with Advisory Committees for Scotland and Wales was appointed in 1947, in accordance with the recommendations of the Ince Committee. The Youth Employment Council established under the terms of the Employment and Training Act, 1948, had a constitution similar to that of the existing council and consequently membership was continued. It issued a report in 1950—Report of the National Youth Employment Council on the Work of the Youth Employment Service, 1947–50.

[4] The number of local education authorities entitled to administer the service was reduced from 315 to 181 by the administrative changes brought about by the Education Act, 1944, which eliminated the old 'Part III' Authorities (i.e., the larger municipal boroughs and urban district councils) which had hitherto been recognised for juvenile employment purposes, and concentrated all the education services in the hands of the county councils and county borough councils.

vocational guidance procedure is becoming increasingly scientific and accurate.

One of the earliest authorities to explore the possibilities of scientific vocational guidance was the city of Birmingham where experimentation in co-operation with the National Institute of Industrial Psychology began as long ago as 1924. Both children given vocational guidance based on scientific tests and a control group of children advised without the aid of such tests were followed up for some years after leaving school, and their employment records provided definite evidence that 'the adoption of scientific methods in vocational guidance improves very considerably the advice that can be given to children leaving school. Children given vocational guidance by these methods and who follow the advice are much more happily placed in employment, are more permanently settled, and are of greater value to their employers than children who are specially guided but do not follow the advice, and also than children who are given vocational guidance in the usual way'[1]—that is without specific scientific tests. Other authorities are experimenting along similar lines. For example, the County Borough of Warrington (Lancashire) has sought the advice of the National Institute of Industrial Psychology in framing its youth employment scheme. Here the Institute has worked out a procedure which includes the appointment in each school of a 'careers teacher' who gets to know each boy and girl individually over a period of years, and helps him to participate intelligently in the planning of his own future; regular visits to the school by the youth employment officer for the purpose of interviewing leavers, and school conferences attended by the head teacher, the careers teacher, the youth employment officer and the child's parents, at which the information obtained about the child is reviewed and a decision reached on the vocational advice to be given.[2]

The schemes evolved at Birmingham and Warrington are but two examples of the work that is being done throughout the country to improve the quality of advice as to employment given to school leavers. The Employment and Training Act laid it down that those authorities who elected to operate a youth employment service in their areas must do so in accordance with a scheme approved by the Minister, and he has decided that such schemes must include vocational guidance to school leavers on lines similar to those laid down in a Model Scheme prepared after consultation

[1] Percival Smith, 'Twenty-five Years of Research in Vocational Guidance', *Occupational Psychology*, Vol. XXV, No. 1, January 1951, p. 39.

[2] J. W. Reeves and V. W. Wilson, *Vocational Guidance in Warrington*, N.I.I.P., 1949, p. 8.

with the National Youth Employment Council.[1] The requirements of this scheme include the enlargement of the pupil's knowledge of different kinds of work available by means of careers talks given by the youth employment officer and by workers in particular occupations, which may be supplemented by films or factory visits; the recording and collation of information about the health, abilities, aptitudes and educational attainments of the pupil; and a personal interview between the youth employment officer and the school leaver.

The framers of the Model Scheme regard the child's interview with the youth employment officer as 'the most important stage in vocational guidance'.[2] It usually takes place in the youngster's last term at school. His parents are invited to attend and the head teacher or some other member of the school staff is frequently present. It provides an opportunity for the officer to meet the child and make his own assessment of him, while the latter gets to know an official of the youth employment bureau on his own ground before meeting him in an unfamiliar setting. When, after leaving school, the child visits the bureau the youth employment officer, thanks to his previous contacts and to the information provided by the school, is in a position to recommend the type of employment best suited to that particular child, and to make concrete suggestions to him.

As is the case in so many of the social services, the success of the youth employment service depends not only on the efficiency of its procedure or on the comprehensiveness of its schemes, but on the calibre of its staff. The key position in the service is held by the youth employment officer, who, if he is to succeed in his work, must be able to win the confidence, not only of teachers, medical officers and others connected with the schools, but also of the representatives of industry, commerce and the professions. He must also know, not merely in theory, but in fact, both what kind of an education the child receives at school, and what goes on in industrial establishments and other places of employment. Last, but not least, he must be accepted by the boys and girls and their parents, so that he will not only be able to formulate advice, but will gain acceptance for it.[3] He must thus be a man of many parts, and the

[1] Ministry of Labour and National Service, Central Youth Employment Executive, *Youth Employment Service*, Memorandum on the Exercise by Local Education Authorities in England and Wales and Education Authorities in Scotland, of their powers under Section 10 of the Employment and Training Act, 1948, H.M.S.O., 1948.

[2] Ministry of Labour and Central Youth Employment Executive, op. cit., p. 5.

[3] 'The ultimate aim of the vocational adviser is to formulate advice and gain acceptance for it.' Report of the National Youth Employment Council on the Work of the Youth Employment Service, 1947–50, p. 13.

recruitment and training of an adequate number of persons competent to undertake this work, and the raising of the officer's professional status, are among the questions which are being considered at the present time. The Minister of Labour in consultation with the Minister of Education and the Secretary of State for Scotland, has set up a committee under the chairmanship of Lord Piercy, Chairman, National Youth Employment Council, to consider them.[1]

The youth employment service is making progress and winning acceptance, but it is not without its difficulties. Employers are under no obligation to notify vacancies, nor are young people compelled to make use of the service in finding work. This means that the officials of a youth employment bureau are not always fully conversant with the vacancies in their area, nor are they in touch with all young people who might be capable of filling them. The Ince Committee regarded this as 'a basic weakness of the system and the prime cause for it not being as effective as it might be',[2] and considered various means, including the possibility of compelling employers to notify all vacancies and all juveniles to report, of overcoming it. After careful consideration it rejected such drastic measures, however, and the only hint of compulsion contained in the Employment and Training Act is the clause[3] which empowers the Minister to make regulations obliging schools to furnish the service with particulars about their leavers and other pupils reaching a prescribed age. These Regulations[4] became operative at the beginning of 1950, but for the present apply only to pupils who are within six months of the date on which they will attain the upper limit of compulsory school age and are likely to leave school on attaining this limit. They do not apply to schools maintained by the Local Education Authority in areas where it operates the youth employment service, but the Minister expects that the information passed on to the youth employment bureau from maintained schools will include particulars similar to those required from other schools by the Regulations.[5] The obligation laid on schools to furnish particulars about their leavers means that youth employment officers now know the numbers of young people entering the labour market in their area each half-year and their potentialities, but not all of them will make use of the youth

[1] The Report of this Committee has now been published.

[2] Report of the Committee on the Juvenile Employment Service, p. 10, par. 32.

[3] Section 13.

[4] The Youth Employment Service (Particulars) Regulations, 1949, S.I. 1949, No. 118.

[5] *Youth Employment Service*, Memorandum to Local Education Authorities, 1948.

employment bureau. The extent to which both employers and leavers do this still remains a measure of the efficiency with which its officials fit the young worker into the right job, and of the understanding and sympathy with which they carry out their task.

A difficulty which faces youth employment officers in some parts of the country, for example in mining and rural areas, is that the variety of the occupations available for young people is very limited. In other parts of the country there is a shortage of openings in skilled trades. Facilities exist for the transfer of young people who wish to train for skilled trades to areas where there are wider opportunities, and financial assistance is available for those who are willing to take advantage of such schemes, but in practice, it is found only too often that boys and girls (or their parents) are unwilling to face the prospect of separation from home. Thus an officer who has had long experience in an area where even now there is considerable adult unemployment, and a serious shortage of openings in skilled and semi-skilled occupations for boys, gives it as his opinion that: 'The extent to which boys and girls, now more mature, more thoughtful, and indeed more critical as to employment, are being able to embark upon the careers for which they have been prepared in schools, must inevitably be determined to a very large extent by the opportunities available in the immediate neighbourhood. Experience shows that only a few parents are willing to allow their children to transfer to other districts where skilled openings occur, although the machinery exists to assist them in meeting their financial obligations.'[1] The majority of young people, whatever their aptitudes, are condemned to remain in their own area, restless and frustrated, either without work, or in jobs in which their capacities are not used to the full.

Shortage of suitable openings for the more able of his applicants may thus be one of the problems of the youth employment officer, at least in some areas; a difficulty which is likely to confront him wherever he works is that of placing mentally or physically handicapped children. The number of these may be comparatively small, but each applicant presents his or her individual problems, and satisfactory placement may require a great deal of care and thought. The youth employment officer dealing with the case must understand not only the general physical and psychological consequences of the young person's handicap, whatever it may be, but also its effect on that particular adolescent, and in many cases should make contact with the home so that he knows something about the child's home background and the attitude of the parents to the disability. It is also necessary to help employers achieve a

[1] City of Liverpool Education Committee, Report of the Youth Employment Service for the year ended 31st July 1949, p. 14.

better understanding of the types of work most suitable for disabled boys or girls, and the ways in which they can be assisted to make good. Thus, for example, there is still a great deal of prejudice to overcome about the employment of educationally sub-normal children. The officer quoted above comments, 'It is frequently overlooked that the boy or girl who is officially classified as "educationally sub-normal" may have as stable a temperament and as pleasing a disposition as his more intelligent brothers and sisters, and may prove as loyal and hard-working an employee on routine duties within his capacity. . . . While they may be slow at learning new operations and require extra patience on the part of the employer in the early stages . . . it has been found in many instances that this patience has been amply repaid, for they develop a loyalty to the employer, and an intense sense of individual responsibility for the piece of work on which they are engaged'.[1]

The placing of handicapped boys and girls is now made easier by the Disabled Persons (Employment) Act which not only compels employers of more than twenty persons to accept at least 3 per cent disabled, but provides for the setting up of special factories (known as Remploy Factories) where they may be employed under sheltered conditions, and encourages schemes for vocational training in suitable cases.[2] The youth employment officer must keep in touch with all these developments, as well as maintaining close contacts with doctors, hospital almoners and other social workers likely to be interested in these cases, and there is much to be said for the appointment in large areas, where numbers warrant it, of special officers, who show a marked aptitude for this kind of work, for giving vocational guidance to handicapped young people.[3]

An interesting development which has taken place since the inception of the youth employment service, is its expansion and adaptation to meet the needs of grammar school pupils. These are making increasing use of it, and while the service as a whole is not yet fully competent in all areas to deal with them adequately, progress is being made, and the goal should be reached within the next few years. Some of the larger cities have had specialist sections for this group of boys and girls for many years, and also make special provision for young people from the technical and commercial schools.

[1] City of Liverpool Education Committee, Report of the Youth Employmen Service for the year ended 31st July 1949, pp. 15–16.

[2] See Chapter XVIII below, where the Act is discussed in more detail.

[3] The employment difficulties which confront such young people are discussed in *Employment Problems of Disabled Youth in Glasgow*. T. Ferguson, A. N. MacPhail and Margaret I. McVean. Medical Research Council, 1952.

THE YOUTH EMPLOYMENT SERVICE

Vocational guidance does not end when the school leaver is placed in what appears to be suitable employment, and the youth employment service in most areas includes measures for keeping in contact with young people placed by the Bureau during the early years of their employment. The procedure most generally used for this purpose is that of holding 'Open Evenings' which the young worker is invited to attend, and is given an opportunity of discussing his work and prospects with the youth employment officers or members of the Local After-care Committee.[1] By these and similar means the young worker is encouraged to look on the youth employment officers as experienced and understanding friends to whom he can turn for counsel and guidance about his employment, who will encourage and advise him if he wishes to better himself, or, if he is unhappy or unsuccessful in his first choice, will give him further help and guidance until he is suitably placed, and can make his own way in the world.

[1] Report of the National Youth Employment Council on the Work of Youth Employment Service, 1947–50, Appendix 11.

During the two years December 1947 to December 1949, 31·4 per cent of the boys and girls invited to Open Evenings throughout the country responded to the invitation, 46·8 per cent of these attending in person, 53·2 per cent replying in writing, but the number varies considerably from place to place.

CHAPTER XV

THE YOUNG WORKER

THE youth employment officer advises the school leaver as to his choice of employment, and is available to help again if called upon; but once inside the factory, shop, or office where he has obtained work, the young worker must make his own way, and he may find adjustment to the new life and conditions difficult. No longer is he the person on whose needs the whole institution is centred; instead he has become an instrument in the production or sale of a given article, and must learn that during his working hours he will be treated functionally rather than personally,[1] his own interests subordinate to those of his employers, be they public corporation or private firm. He must also become accustomed to longer hours, shorter holidays, and more monotonous, yet more exacting, tasks than he had at school. In the larger and more progressive firms the staff of the personnel management department will watch over him and assist him through this initial period of adjustment, or he may be helped by a kindly foreman or fellow-worker, but there appears to be some evidence that not all young people are so fortunate.[2]

Increasing attention is now being given to the question of the best methods of induction and training for young workers, and the advantages which will accrue to the firm itself as well as to the boy and girl entrants if there are good reception arrangements, and some form of training is given, even to those young people who are taking up relatively unskilled work, are emphasised by the Central Youth Employment Executive, and appreciated by an increasing number of industrialists.[3]

[1] Cf. Ministry of Education, Central Advisory Council for Education (England), *School and Life*, H.M.S.O., 1947, p. 52. 'The object of employment is the product; in education it is the process which matters. In industry the worker is part of a process ending in goods; in education he is an end in himself.'

[2] 'The behaviour of some men who are attached to them is so different from the way in which, one supposes, they would treat children of their own, as to emphasise how necessary it is to select carefully those who are given immediate responsibility for directing juvenile employees'. Ibid., p. 48, cf. J. Macalister Brew, *Informal Education*, pp. 158–60.

[3] See leaflet, *Training and Employment of Young Workers in Industry*, prepared by the Central Youth Employment Executive and published by the Ministry of Labour and National Service, September 1949.

Thus from the time when he enters his first job the young worker's progress and well-being will depend in large measure on the attitudes of his employers and fellow-workers towards him, and these are matters which cannot be ordered by legislation. What the State does is to insist that his physical environment is safe and healthy, which means regulating conditions in all occupations, and prohibiting his employment altogether in certain of them which are known to be harmful;[1] regulate his hours of employment, and set up wage-fixing machinery in certain trades where ordinary methods of negotiation are exceptionally difficult or impossible.[2]

It took years of endeavour on the part of humanitarians to induce the rulers of the nation to accept the principle that society, acting through the State, must intervene in industry to protect young people from being worked beyond the limits of human endurance in the interests of greater production. Child labour was prevalent before the Industrial Revolution, and the wrongs of one category of such children, the climbing boys, roused philanthropists to seek redress by Act of Parliament as early as 1788.[3] The transference of industry from home to factory emphasised the inhumanity of the treatment of children of the labouring classes and drew attention to it. The first attempt at restraining mill-owners from overworking the children they employed was the 'Act for the Better Protection of the Health and Morals of Apprentices and others Employed in Cotton and Other Mills and Cotton and Other Manufactures', passed in 1802, but in spite of its lengthy and comprehensive citation most of its clauses applied only to apprentices, that is, the pauper children sent in wagon-loads from the parish workhouses of London and other large towns, and bound over to their masters until the age of twenty-one. These pauper apprentices were employed in large numbers during the early years of the Industrial Revolution, when the cotton and woollen mills were run by water-power, and situated high up the Pennine valleys away from centres of population. When steam replaced water as a source of power the place of the paupers was

[1] Prohibitions of this nature are contained in the Lead Paint (Protection against Poisoning) Act, 1926; Cellulose Solutions Regulations, Chromium Plating Regulations, Pottery Regulations and others.

[2] The bodies set up are now generally known as Wages Councils. They consist of equal numbers of workers and employers, together with three neutral members. The wages fixed in accordance with their recommendations can be enforced in the criminal courts.

[3] The Act was unfortunately completely ineffective. It was not until nearly a century later that this particular form of cruelty to children was finally brought to an end.

[4] The conditions under which the children worked and the cruelties they suffered are described in the standard social and economic histories of the period, e.g., J. L. and B. Hammond, *The Town Labourer*, ch. viii.

largely taken by 'free' children, that is the children of the hand-loom weavers and other badly paid or unemployed workers, who were obliged to send them to the mills to keep the family from starvation. The next effort to protect the children, namely the Cotton Factories Regulation Act, 1819, applied to them. In fact, neither of these Acts accomplished much, as enforcement was left in the hands of the Justices of the Peace, and it was not until 1833 that factory legislation became effective, owing largely to the inclusion of a clause in the otherwise somewhat emasculated Act passed that year,[1] which authorised the appointment, by the Crown, of inspectors armed with judicial and executive powers. From then onwards H.M. Inspectors of Factories played an increasingly important part both in seeing that successive enactments of Parliament were obeyed, however unpopular they might be, and, through their Annual Reports, drawing attention to ways in which the law could be improved and strengthened.

By 1833 the idea of state protection for children who worked in factories was becoming generally accepted, but the struggles of Shaftesbury, Fielden and their supporters to get the Ten Hours Bill passed show how reluctant and how limited this acceptance was. Slowly, however, the scope of factory legislation was enlarged,[2] and by the end of the century it included extensive and detailed provisions limiting hours of work and ensuring a measure of health and safety in factories and workshops of all kinds. This legislation was consolidated in 1901, and the Act then passed proved an effective instrument for ensuring reasonably good conditions in factories. But as standards gradually improved, and new processes, involving new risks, were introduced the need for new legislation became apparent. This was met by the Factories Act, 1937, which is now the principal Act protecting factory workers. Its provisions were extended, and in some respects amended, by the Factories Act, 1948.

[1] An Act to Regulate the Labour of Children and Young Persons in the Mills and Factories of the United Kingdom, 1833. It applied only to cotton and other textile mills, and decreed that no child under the age of nine was to be employed at all, children under the age of thirteen were not to work more than nine hours a day, and young people between thirteen and eighteen not more than twelve a day. Apart from the appointment of inspectors discussed above, the Act was noteworthy in that it contained a clause obliging children between the ages of nine and thirteen who worked in factories to attend school for two hours on six days a week. The clause was extremely difficult to enforce, and in some areas was almost a dead letter—but it was the first attempt to introduce compulsory education.

[2] These developments are summarised in the Annual Report of the Chief Inspector of Factories and Workshops for the year 1932, Cmd. 4377. This Report included a historical summary of the developments which had taken place since the appointment of the first H.M. Inspectors in 1833.

In considering the provisions of the Factories Acts it is important to bear in mind that such legislation lays down minimum and not optimum standards.[1] They are, and must be, standards which even the smallest firm should carry out, and could justifiably be prosecuted for failure to do so, but, from the first, the inspectors administering the Acts have regarded it as their duty not only to insist on the maintenance of the standards laid down by law, but to interest themselves in the experiments of those progressive firms who achieve something better, and encourage others to follow their example. Further, factory inspectors, when insisting on the carrying out of the letter of the law, seek to ensure that both occupiers and workers understand the reasons for its provisions, and try to obtain their willing co-operation in guaranteeing the safety, health and welfare of the workers.

The scope of the Factories Act, 1937, is wider than that of its predecessors. Its provisions cover not only factories and workshops as generally understood, but shipbuilding yards, docks, building sites, film studios, laundries, whether commercial or run in connection with hospitals or charitable or reformatory institutions, and in fact any premises where persons are employed in manual labour on any process incidental to the making, altering, repairing, demolition or adaptation for sale of any article.[2] Moreover, young persons employed running errands or working as van boys in connection with a factory are also protected.

The Act is designed in the first place to safeguard the health and safety of workers, and it includes detailed provisions for securing adequate standards of cleanliness, space, temperature, lighting, ventilation and sanitation, the fencing of machinery, the safe working of the plant, and provisions in case of fire. Statistics over a number of years having shown that young people were more liable to accidents than their elders,[3] the Act contains a clause[4] prohibiting young people (that is, persons under eighteen years of age) from operating specified machines of a dangerous nature[5] unless they have been fully instructed as to their dangers and the precautions to be observed, and have either received sufficient training in working the machine or are under the adequate supervision of a person who has a thorough knowledge of it. In spite of this provision the special difficulties and

[1] Cf. the overcrowding standards laid down in the Housing Acts of 1935 and 1936 discussed above, Chapter VI.

[2] Factories Act, 1937, Section 151, which elaborates this definition further.

[3] The reasons for this are discussed in the Annual Report of the Chief Inspector of Factories and Workshops for the year 1936, Cmd. 5514, ch. iii.

[4] Section 21.

[5] These machines are specified under the Dangerous Machines (Training of Young Persons) Order, 1938.

strains of the war years were accompanied by an increased accident rate among young as well as adult workers, but there has been a marked diminution since. This, while doubtless in part due to the raising of the school-leaving age, is also attributed by the Factory Department to the increased attention paid by many managements to the training of young workers, and in particular to the emphasis now being placed on the importance of their supervision and of teaching them the elements of safe working.[1] Nevertheless, there is still room for improvement, for accidents due to lack of supervision still occur, and it is sometimes found that the instructor has not realised, or paid sufficient attention to, the limitations of the young person he is instructing. Patient educational work on the part of both inspectorate and all grades of management is still essential to reduce the number of avoidable, but sometimes, unfortunately, permanently disabling, accidents.[2]

The establishment of minimum standards of health and safety was early recognised as being within the scope of factory legislation, but in the development of more varied and extensive services to enhance the general well-being of the worker the lead has usually been given by enlightened employers, the Factories Inspectorate limiting itself in the main to encouragement and advice. The importance of paying attention to the well-being of the workers, and establishing good relations between management and men, is now more widely recognised than ever before, but the provision of welfare services by individual firms is no new thing. The day nurseries, schools, community centres, model villages and medical services on which many of our modern industrialists pride themselves are but the twentieth-century equivalents of Robert Owen's Institution for the Formation of Character opened at New Lanark in January 1816; the model village Titus Salt built round his woollen mills outside Bradford in 1854, and the surgery fitted up at the factory of a Lancashire firm, which as long ago as 1845 was employing a works doctor. Even works outings and savings banks had their early nineteenth-century forerunners. These were sporadic experiments, but after the turn of the century more and more firms began to make provisions for their workers over and above the health and safety requirements of the Factory Acts, and some even went so far as to appoint welfare workers to be responsible for their general well-being. The 1914–18 war accelerated these developments, and during the succeeding years 'welfare', which had hitherto centred round the material needs of the worker, gradually developed and merged into the much wider

[1] Annual Report of the Chief Inspector of Factories for the year 1946, Cmd. 7299, p. 11.

[2] Annual Report for the year 1949, Cmd. 7839, p. 45.

conception of personnel management, with its emphasis on human relations, and its concern with such matters as the engagement and training of the worker, wages, and joint consultation, as well as with health, safety, and the provision of amenities.[1] These developments were watched with interest by the Factory Department, but here, as in other directions, legislation could only insist on minimum standards of material well-being, and the welfare clauses of the 1937 Factories Act were confined to such elementary requirements as drinking and washing facilities, cloak-room accommodation, seating, and first-aid. However, the Secretary of State was empowered to make regulations on other matters affecting the welfare of employed persons or any class of them,[2] and during the Second World War the Department, now transferred from the Home Office to the Ministry of Labour, did much in the face of considerable difficulties to encourage and, where necessary, enforce, higher standards of well-being for the work-people thronging into the factories and workshops in response to the call for increased production.[3] Moreover, sensitive to the personal problems the war was accentuating, and realising the contribution personnel management could make towards their solution, the Department created its own Personnel Management Branch, staffed by trained advisers whose function it was to assist firms to establish their own personnel organisation, and advise those smaller firms who could not be expected to achieve this.

General interest in the human problems of industry and the contribution management, labour and the State can make to their solution has continued, and, if anything, deepened since the war, and personnel departments are extending their scope and increasing their responsibilities. Some of these extended facilities such as selection and training directly affect the welfare of the

[1] 'There is no difficulty in distinguishing between welfare work and personnel management. The former is in fact included in and is part of the latter . . . a firm should be so organised that the well-being of its workers is safeguarded and promoted at every point. Yet this cannot and should not be the sole object of personnel policy which aims at the best and fullest use of the workers' capacities and energies. . . . Personnel management is concerned with a vastly wider field of activities, while welfare work is usually confined to the provision of certain amenities for workers—such things as health and safety precautions, suggestion schemes, canteen and sports clubs. . . . Welfare alone cannot make any effective contribution to the solution of those deep-seated human problems which are endangering the whole structure of industry to-day.' H. W. Locke, *Fundamentals of Personnel Management*, 1943, pp. 17–18. This is one of a number of pamphlets published by the Institute of Personnel Management, describing and discussing various aspects of the principles and practice of personnel management, a topic outside the scope of this book.

[2] Op. cit., Section 46.

[3] For example by making an order insisting on the provision of canteens in larger factories.

young worker, but even those aspects of personnel management which may be of little interest to him, such as schemes for joint consultation, are in reality of great importance, because of their effect on the morale of the factory as a whole. This not only makes a great difference to his present happiness, but may influence his whole future attitude towards industrial relations.

Conditions inside the factory do much to influence the moral and physical development of the young workers, but equally important are leisure-time opportunities for healthy recreation and further education.[1] This is but one of the reasons why the hours of young persons are limited by law, although, with certain exceptions, the State does not attempt to fix the hours of adult male workers. Women, like young people, are regarded as 'protected persons', and like them may not as a general rule work more than nine hours a day or forty-eight hours a week. This maximum is reduced to forty-four hours in the case of boys and girls under sixteen, but a limited amount of overtime is permitted to young people between sixteen and eighteen, and to women. In addition to limiting the length of time actually worked, the Factories Act seeks to prevent undesirable 'spread-over' by limiting the length of the working day, inclusive of meals and rest breaks, to eleven hours.[2] In general, young persons may not start work before 7 a.m.[3] or finish later than 8 p.m., or, in the case of young people under sixteen, 6 p.m. The Act also prohibits women and young persons from working more than 4½ hours without a break of at least half an hour unless there has been a ten-minute rest-pause, in which case the period of continuous employment may last for five hours.[4] On Saturdays work must cease at 1 p.m. Since this legislation became operative, the school-leaving age has been raised, and the hours worked by adults as well as juveniles have been shortened in many industries, and it may be that the time is coming when these provisions should be modified. This question will be discussed when the hours and conditions of young people employed in non-industrial employments have been described, as it is an issue affecting all classes of young workers.

[1] These are described in the chapter which follows.

[2] Factories operating a five-day week may extend the hours worked in any one day to ten, and the period of employment to twelve.

[3] Section 83 of the Act permits the Secretary of State (now the power rests with the Minister of Labour), by Regulations or by Order, to allow women or young persons to begin at 6 a.m. The only such exceptions made to date are the Bread, Flour, Confectionery and Sausage Manufacture (Commencement of Employment) Regulations, 1939, which allow women and young persons to start at 6 a.m. in such factories.

[4] Under Section 87 of the Act boys over 16 who are employed with men and whose continuous employment is necessary to enable men to carry on their work, may be employed for a five-hour spell without a ten-minute break.

A useful provision for safeguarding the health of young workers is contained in Section 56 of the 1937 Act which prohibits them from being employed to lift, carry or move any load so heavy as to be likely to be injurious.

One of the most difficult tasks confronting the four intrepid men who in 1833 set out to enforce the factory legislation was to ascertain the correct age of the children employed. Registration of births was not made compulsory until 1837, and for some years inspectors were forced to depend on certificates of age issued by surgeons many of whom took this duty lightly, while some even faked certificates deliberately.[1] Consequently, in 1844 Inspectors were empowered to appoint Certifying Surgeons whose duty it was to examine young people entering factory employment, and certify that they were satisfied that the child was of age to be employed, and that he was not incapacitated by disease. As time went on, and it became possible for the child to procure a birth certificate, it was no longer necessary to insist on a medical examination to determine his age, but such examinations were retained as tests of fitness for factory employment, and by the Act of 1901 the Certifying Surgeons were empowered to attach conditions to the certificates they issued. This was an advance, but in many cases the examination remained perfunctory and a Departmental Committee which considered the question in 1924 condemned the system as unsatisfactory. The Factories Act, 1937, led to some improvement, as it empowered the 'Examining Surgeon', as he then became,[2] to issue a temporary or modified certificate, and to ask the local education authority for the young person's school medical record, if he thought it would help him decide as to his fitness.[3]

There was still no statutory medical supervision after entry, however, unless the doctor asked for re-examination in connection with the issue of a temporary certificate, and the initial medical examination was only required for boys and girls under the age of sixteen. The Factories Act, 1948, has improved matters by extending this age limit so that young persons under the age of eighteen are now subject to medical examination not only on entry, but annually thereafter. The later Act also included certain employments within the scope of these rules,[4] which, although subject to other provisions of the principal Act, were not covered by the sections relating to the medical examination of young workers. This means that Certificates of Fitness are now required for young

[1] Report of the Chief Inspector of Factories, 1932, p. 12.

[2] The Factories Act, 1948, changed his title to that of 'Appointed Factory Doctor'.

[3] Factories Act, 1937, Section 99.

[4] Factories Act, 1948, Section 2. Young Persons (Certificate of Fitness) Rules, 1948, S.I. 1948, No. 2162.

people employed in the loading, unloading and coaling of ships and certain other work on ships in harbour or wet dock, building operations and engineering construction as well as for those employed in factories.

The changes made in the 1937 and 1948 Acts thus mark a definite advance towards the goal of the proper supervision of the health of the young worker, but there is still room for improvement. In the first place, there is no real link between this examination and the other health and medical services,[1] and secondly it is confined to young people in employments covered by the Factories Acts, and there appears to be nothing to prevent a boy or girl rejected by the Appointed Factory Doctor from obtaining equally strenuous or otherwise unsuitable work in connection with a shop or warehouse, outside the scope of factory law, where he will be without medical supervision. It may be possible to overcome this difficulty when those sections of the Education Act relating to continued part-time education in county colleges are implemented, since boys and girls at work will then remain within the scope of the school health service. By establishing close co-operation between this extended service, the youth employment service, the Appointed Factory Doctor and others concerned with the health of the workers, the health of young persons in all kinds of employment should in time be properly safeguarded.

The absence of any requirement about fitness for employment or for continued medical supervision, is but one illustration of the fact that legislation to safeguard the health and welfare of young people in non-industrial employments is less comprehensive than that covering young people in factories. The Shops Act, 1934, includes clauses which are designed to establish minimum standards of health and comfort for people employed in shops, and restricts the hours of young persons, while as the result of the findings of a Departmental Committee set up in 1937,[2] the Young Persons (Employment) Act, which restricts the hours of boys and girls employed in certain categories of work outside the scope of the Factories and Shops Acts, was passed in 1938. As a result of the passing of these two Acts the hours of work of boys and girls in employments covered by them are limited to forty-eight hours for juveniles over sixteen, forty-four for those under this age. Like the Factories Act they also include clauses fixing the maximum length of continuous spells of employment, limiting the daily spread-over and providing for a weekly half-holiday. Their enforcement was

[1] The power given to the Appointed Factory Doctor to examine the young person's school medical record is very little used.

[2] Departmental Committee on the Hours of Employment of Young Persons in Certain Unregulated Occupations, March 1937.

entrusted to the local authorities, and there appears to be some reason to believe that their control has not always been as effective as the central government's supervision of factories. In other ways, too, the position with regard to these young workers is not wholly satisfactory, and in 1946 a Committee was set up by the Home Office and the Scottish Home Department to investigate and make recommendations concerning those provisions of the Shops Act which relate to times of closing; the statutory provisions relating to the health, safety and welfare of persons not protected by the Factories, Mines and Quarries Acts; and the statutory legislation of the hours of employment for young persons.[1]

The Committee issued its Final Report in March 1949. After a careful review of existing provisions it makes various recommendations. While they are more limited than many would have liked and make no fundamental changes in existing legislation, they would, if they became law, materially improve the position of many young workers, bringing their hours and conditions of work more in line with those enjoyed by the employees in progressive firms. The Committee recommends the extension of protective legislation to cover juveniles in certain employments, such as office work, rail and road transport and various miscellaneous employments not now within its scope, but practical considerations led it to exclude agriculture, forestry, fishing, shipping, and private domestic service from any restrictions. In view of the raising of the school-leaving age to fifteen, and the expressed intention of the Education Act that this shall become sixteen as soon as possible, it proposes that the distinction between juveniles under and those over sixteen be abolished, and suggests that the maximum weekly working hours for all young people under eighteen, whether working in factory, shop or occupation other than those listed above, should, with certain specified exceptions, be limited to forty-five hours a week. Modifications in the existing law affecting overtime, continuous spells of work, spread-over, night intervals, half-holidays, and weekly rest-days, are also recommended.[2] Since these proposals would involve a slight increase in the maximum hours worked by young people under sixteen, they may be regarded by some as inadequate, or even slightly retrograde. In making them the Committee has clearly been influenced both by the need for avoiding any serious dislocation in industry or commerce which might arise if the hours of young people were very

[1] Home Office, Scottish Home Department, *Health, Welfare and Safety in Non-Industrial Employments, Hours of Employment of Juveniles*, Report by a Committee of Enquiry, H.M.S.O., 1949, Cmd. 7664.

[2] These recommendations are set out in tabular form in Appendix C of the Report.

different from those of adults, and any possibility that its recommendations might have the effect of reducing output. Similar practical considerations have led it to reject the idea of a comprehensive code governing conditions of employment for all young workers, desirable as this might be.

The Report and Recommendations of the Committee on Health, Welfare and Safety in Non-industrial Employment illustrates the possibilities and limitations of state action in securing good conditions for the young worker. In the main it is restrictive rather than creative, but it constitutes a constant reminder that although the ends of industry and commerce may be the production and distribution of goods, and the young worker is a means to these ends, he is also an immature person whose healthy all-round development must be safeguarded, and the State has a special responsibility for seeing that this is done.

CHAPTER XVI

THE SERVICE OF YOUTH

THE 'Service of Youth' is the rather ambiguous official title given to the efforts made by statutory authorities and voluntary organisations to provide young people with opportunities for informal education, social intercourse and the creative use of leisure through membership of a group. It is centred round, although not confined to, the fourteen–eighteen age range, and is in the main concerned to meet the needs of the young worker, but many organisations accept both younger and older members, and there is a tendency to widen its scope.

The organisations which go to make up the youth movement may be attached to parent organisations such as churches, political parties or settlements, or they may be completely independent, but to a greater or lesser degree they are self-contained, with their own membership, activities, standards and leadership. The movement as a whole is based on the assumption that the adolescent gains from membership a community of his own, which forms an alternative to the compulsory groups of home, school and work which otherwise make up his world. This community should provide boys and girls with opportunities for developing friendships, the stimulus of group activity, scope to work out their own plans, and training in the management of the affairs of their own society under the leadership of mature people.[1] It thus provides experience of a small community which stands or falls by the young people's own efforts.[2]

This underlying assumption, that membership of a small, independent group fosters the development of the adolescent's personality, has not passed unchallenged. It has been argued that youth clubs, as they are organised to-day, contribute towards the disintegration of family life and isolate boys and girls at a critical stage of their development, keeping them in an atmosphere of artificial immaturity and hindering the natural transition from childhood to the adult community.[3] The founders of the Peckham

[1] Central Advisory Council for Education (England), *School and Life*, p. 69.
[2] Planning, Vol. XIV, No. 280, *The Service of Youth To-day*, p. 285.
[3] This criticism is discussed in *The Service of Youth To-day*, p. 298.

Centre go so far as to say that 'Perhaps the segregation of adolescents all at the same stage of development, when they should be freely learning from every possible degree of maturity, is one of the worst crimes committed against growing boys and girls'.[1] These are two apparently divergent points of view, but it seems that both close association with the adult community and opportunities for withdrawal from it into a group of his own are desired and needed by the adolescent as his development proceeds. As the Rev. Bryan H. Reed puts it, 'The dilemma in which we are caught up arises from the difficulty of creating a social setting for youth work which will give full recognition to two conflicting facts—the fact that much can be given to adolescents through their association with children and with adults, and the fact that the younger adolescents desperately need a society of their own where away from parental influence they can make their first explorations of a wider world'.[2] If this is so then both family clubs of the Peckham Pioneer Health Centre type and the more orthodox youth clubs have their place in community provision in any particular area. But the self-contained club should never lose sight of the fact that the age group for which it caters is essentially a stage of transition from childhood to adult life, and such organisations exist, not simply as ends in themselves, but 'as means whereby their members may the more naturally and organically grow into full adult citizenship'.[3] Here the youth organisation attached to a church, settlement, community centre or other adult society has the advantage, as the transition can take place more easily and naturally, and further, these organisations may be among the interests of older people who form part of the boy's or girl's normal background. Isolation from the adolescent's ordinary social and cultural background so that it is not fully integrated into his normal life is one of the weaknesses of the independent youth club, and one which it is very hard for it to overcome.[4]

From the administrative standpoint the 'service of youth' is a partnership between statutory and voluntary organisations, a partnership which has evolved to meet the changing needs and ideas of successive generations. Until the First World War the provision of recreational facilities for young people was in the hands of the voluntary organisations. The State interested itself in the vocational education of those who wished to improve their chances in life or increase their skill in technical college or evening institutes, but voluntary organisations, such as the Y.M.C.A., Y.W.C.A., Brigades, Scouts, Guides, and clubs which sought to provide

[1] Innes H. Pearce and L. H. Crocker, *The Peckham Experiment*, p. 223.
[2] *Eighty Thousand Adolescents*, 1950, p. 158. [3] *School and Life*, p. 75.
[4] Pearl Jephcott, *Rising Twenty*, 1947, p. 166.

opportunities for healthy recreation for young workers were left to carry on without assistance or interference. Much good work was done, but only a minority of young people were reached, and then, as now, the orthodox oganisations often failed to attract the young people whose needs they particularly wanted to meet—those from poor homes who wandered about the streets in their leisure hours, liable to drift into immorality and crime. The increase in juvenile delinquency during the 1914–18 war led the State to take action[1] by encouraging the setting up throughout the country of Juvenile Organisation Committees, made up of representatives of the local education authorities, voluntary organisations, and persons particularly interested in youth work. In most areas this experiment was only half-heartedly carried out, however, and throughout the inter-war years the initiative remained with the voluntary organisations. They were, however, able to obtain some assistance from their Local Education Authorities by invoking Section 86 of the Education Act, 1921, which empowered these authorities to provide for the social and recreational needs of young persons under the age of eighteen, whether attached to schools or evening institutes or not.

The Second World War, like the First, resulted in major developments in youth work. This time the Board of Education acted immediately, for it feared that 'the strain of war and the disorganisation of family life would create conditions constituting a serious menace to youth'.[2] Hence, as early as September 1939 it established the National Youth Committee, later replaced by the Youth Advisory Council, and in November of the same year issued Circular 1486 *In the Service of Youth*, which laid down the lines along which it hoped the Service would develop. Local Education Authorities responsible for higher education were urged to establish Youth Committees composed of representatives of the education committee and voluntary organisations, together with individuals concerned with the welfare of youth, and the Circular expressed the hope that 'in the Youth Committee the individual traditions and special experience of youth possessed by the voluntary organisations will be joined with the prestige and resources of the Local Education Authorities'. Underlying aims and administrative proposals were thus similar in 1916 and 1939, but in 1939 their implementation was pursued with greater vigour. Youth Committees were set up, and organisers appointed in counties and county boroughs throughout the country, while in some areas these Committees, as well as

[1] It is significant that the first move came not from the Board of Education but from the Home Office. At the end of the war the Board of Education took over the responsibility.

[2] Board of Education Circular 1486, *In the Service of Youth.*

encouraging and assisting voluntary bodies, established youth clubs of their own in those parts of their districts where provision was inadequate.

Thus the first war-time reaction of those concerned about the welfare of young people was an attempt to protect them from the war's moral dangers, but soon a significant change occurred. In the stress of total war the services of youth were needed, it must share in the nation's struggle for survival. This resulted in the development of the pre-service organisations, the Ranger Home Emergency Service and other offshoots of existing organisations, and spontaneous efforts by boys and girls to organise themselves for useful service. The enthusiasm with which some young people who had remained indifferent to previous attempts to reach them responded to this new approach is significant, and suggests that some of the more spirited young people who refuse to respond to efforts made for their good, will do so if they can discover a purpose in the life of the community with which they can identify themselves. This stimulus of a common purpose operated during the war, but it appears to have been lost again,[1] and it is doubtful if the administrative and other developments discussed below can compensate for this loss.

The war years witnessed a rapid expansion of the youth service, both in the numbers of young people brought within the scope of its various organisations and in the range and variety of opportunities available for them. Their most important administrative legacy is the partnership between the Ministry of Education, the local authorities and the voluntary organisations which was established then. Since the passage of the Education Act, 1944, the terms of reference of this partnership have been widened. The service of youth now forms part of a comprehensive scheme of further education in connection with which it is the duty of Local Education Authorities to secure full-time and part-time education for persons over compulsory school age, and 'leisure-time occupations in such organised cultural, training and recreative activities as are suited to their requirements, for any persons over school age who are able and willing to profit by the facilities provided for them'.[2] Thus the rigid upper age limit for L.E.A. assistance has been removed and youth clubs are given wider scope.

This is an advance, and has many advantages, but some workers in voluntary organisations are concerned lest the present partnership in youth work should, like the partnership in education, end in the dominance of the State, and the creation of a state-controlled

[1] Cf. L. J. Barnes, *Youth Service in an English County* (Report prepared for King George's Jubilee Trust), pars. 41–3.

[2] Education Act, 1944, Section 41 (b).

and organised youth service in which the voluntary organisations would be relegated to a subordinate position. An Administrative Memorandum issued by the Ministry in December 1945, makes it clear that this is not present policy, for it states quite specifically, 'We thus arrive at the basic administrative principles of youth service, namely a triple partnership between the Ministry of Education, the local authorities and the voluntary organisations (including the churches), aimed not at establishing a national youth movement, but at creating facilities and opportunities for young people everywhere'.[1] In spite of this the doubt remains, and is strengthened by the Ministry's plans for establishing county colleges. These are intended to provide compulsory part-time education for young people between the ages of fourteen and eighteen, and the Ministry evidently hopes that leisure-time activities will in time be centred round them, as 'this will greatly assist in the creation of a corporate spirit in the college'.[2] It is true that the Ministry adds, rather hesitatingly, 'in addition to those young people who spend their evenings at county colleges there may well remain greater numbers than are at present active in the youth service to be provided for in the traditional youth organisations',[3] but this is small consolation to the organiser of a voluntary association, who sees not only his members, but also his leaders attracted to the statutory service.

The whole problem of the relationship between the statutory and voluntary services concerned with the welfare of young people is discussed by Mr. L. J. Barnes in his Report to King George's Jubilee Trust, *The Outlook for Youth Work*. He stresses the fact that, since attendance at youth clubs is optional, a matter of personal choice, they are essentially 'focal points of spontaneous activity and experimental work'. Voluntary organisations should concentrate on this aspect of their work and face the fact that official agencies may be the best consolidators and the proper providers of well-established social services. Mr. Barnes' views have not won universal acceptance however. The premise on which they are based, namely that by their nature voluntary associations are better fitted for experimental and statutory bodies for more standardised work, is challenged by the Rev. B. H. Reed, who points out that the survey of youth work in Birmingham, for which he was responsible, revealed that interesting experimental work was being carried out by the L.E.A., while 'the voluntary organisations tended on the whole to follow a rather stereotyped method

[1] Quoted in *The Church and Youth*, Report of the Church of England Youth Council, p. 40.

[2] Ministry of Education, *Further Education*, 1947, par. 162, p. 65.

[3] Ibid., par. 163.

and programme'.[1] He concludes, 'We wonder if it is possible to generalise on this question, because it is probable that all genuine experiment is to be found, not in the resolution of any committee, either statutory or voluntary, but in the vision of an inspired individual who may find his opportunity in either field'.[2] In his view the real strength of the voluntary youth movement is that it consists largely of small groups in which personal relationships are strong, for outside their homes young people to-day live in an impersonal world which encourages social irresponsibility. Hence it is desirable 'that they should become part of the life of some group which is small enough to be a true community, to introduce them to genuine personal relationships and give them the opportunity of discovering themselves and making a contribution of their own in a society of their contemporaries'.[3] Further, in a voluntary organisation the young person who in his day-to-day work is a member of an acquisitive society, in which the main object is to gain as much as possible with as little effort as possible, gets to know people who are prepared to work hard and give freely of their time without being paid for so doing. This, Mr. Reed thinks, is one of the most valuable experiences membership in a voluntary youth organisation can bring. Finally, the voluntary organisation has an important part to play in the youth service by helping to ensure that variety of provision which is essential if young people of differing types are to be attracted.

Youth organisations, whether statutory or voluntary, may be divided into three main types. First, there are those which are closely linked with some parent organisation, and which exist, not as ends in themselves, but as means by which the younger generation are trained in the beliefs and principles of the parent body and learn to identify themselves with it. The youth groups connected with the churches form the majority here, but this division also includes youth movements sponsored by political parties and the co-operative youth movement. Secondly, there are what are sometimes called the uniformed organisations, such as the Scouts, Guides and Brigades, whose local units may or may not be attached to some adult organisation such as a church, but which have their own definite aims, set out in clearly defined codes, which not only outline the principles underlying the movements' work, but designate the means by which they are to be carried out in practice. Finally, there is the heterogeneous mass of boys', girls' and mixed clubs and youth centres of all types and sizes. 'They may be run by an *ad hoc* committee and be entirely a law unto themselves, or they may be promoted by or affiliated to a national youth organisation, or they may be entirely provided and "serviced"

[1] *Eighty Thousand Adolescents*, p. 55. [2] Ibid., p. 147. [3] Ibid., p. 145.

by the L.E.A. They may exist to promote a variety of purposes and make certain demands on their members, or they may exist for no purpose discernible by them, and one of their methods may be to make no explicit demands on those who join them.'[1] They vary very considerably in size, premises, frequency of opening, leadership and activities. Recreational facilities such as dancing, games and opportunities for social intercourse usually figure prominently in their programmes, but the clubs may also provide informal classes, possibly with the assistance of teachers supplied by the Local Education Authority. Their characteristic feature is, however, that membership of the club is regarded as an end in itself, and more importance is attached to the group than to any purpose or activity to which it may lend itself, for so, it is maintained, membership of the group gives the adolescent freedom and opportunity to develop his own activities and interests.[2]

The variety of the service of youth is so great that it is neither easy nor safe to generalise about its achievements and limitations, its success or failure. There are some hopeful auguries. One of these is that those who sponsor the movement are realising to an increasing extent that it is little use providing facilities for leisure-time activity without taking into account the adolescent's other needs and opportunities, and relating his club experiences to his home, neighbourhood and conditions of employment. The service of youth is concerned with the physical, mental and spiritual development of the adolescent, and hence must ally itself with all agencies—the home, the church, the school, the youth employment service, the factory manager and welfare worker, the health service—which may in any way help or hinder in this development, so that each may play its part in the full co-operation with the rest, in assisting the boy or girl in his growth from childhood to maturity.[3]

A second hopeful feature in the youth movement is its growing realisation that to be effective it must be democratic. The 'of youth' must be understood in the genitive, as well as in the dative case. In many clubs and other groups self-government is still in its infancy, it is accompanied by many difficulties, and the rate of progress necessarily varies with the age and type of the members

[1] Eileen Younghusband, *Employment and Training of Social Workers*, p. 118.

[2] *The Service of Youth To-day*, p. 291.

[3] This is discussed in chs. vii and ix of Barnes, *The Outlook for Youth Work*, and also in his earlier report, *Youth Service in an English County*, pars. 182–6, pp. 79–80, 'The Ecological Approach'. The same idea is expressed in the comprehensive recommendations of the Liverpool Youth Organisations Committee Report, *The Changing Service of Youth*, 1947, while the first recommendation of the report of the Youth Advisory Council, *Youth Service After the War*, published in 1943, is that 'At the earliest possible moment a building programme be carried out which will guarantee healthy conditions of living for all young people'.

as well as with the traditions of the organisation. But progress is being made. The value of securing the active participation of the young people themselves in the management of their own organisations is recognised, for example, by the creation in many areas of Youth Councils, composed of the members themselves, side by side with the Youth Committees.

Another modern development is the widening of the age range of the service. In its early days the youth service was mainly concerned with the young worker, and the age range fourteen-eighteen is still the focus of the work, but increasing attention is being paid both to younger children and young adults.[1] The need for some recreational provision, particularly in congested areas, to absorb the energies of children out of school hours, has long been recognised, and play centres were started under the inspiration of Mrs. Humphrey Ward before the end of the last century. The provision of such centres, together with play spaces and junior clubs and other organisations for slightly older children, is still woefully inadequate, however, and the need for administrative action to speed up provision of facilities of this nature is stressed in the Second Report of the Central Advisory Council on England.[2] This suggests that 'Out of School' Committees, constituted on similar lines to the Youth Committees, be established by Local Education Authorities, and that these committees should survey existing facilities in their areas and see what extra provision is needed. Other recommendations include grant aid to voluntary organisations concerned with the work, training courses for workers, and the suggestion that provision should be made to help parents to arrive at a true understanding of the interests of their children and how to provide for them. The proposal that parents should be associated with this community provision is a significant indication of the efforts now being made to make services for children a co-operative enterprise in which parents are encouraged to share, and may be compared with the recent growth of the Parent-Teacher Associations.

The question of provision for young adults is in some ways more complex than that of provision for children and adolescents. Military service, courtship, marriage, and the starting of a family,

[1] Mr. Barnes suggests that the primacy of the fourteen to twenty age group within the youth service is no longer justified and proposes as an alternative an eighteen-year programme divided into two sub-sections, a junior group (seven to sixteen) concerned with children still at school and with influencing the home in ways calculated to raise the level of parentcraft; the senior group (sixteen to twenty-five) for easing the transition to full-time employment and straddling the period of conscription. *The Outlook for Youth Work*, ch. xii. This proposal has not won general acceptance from youth workers.

[2] *Out of School*, H.M.S.O., 1948.

now become part of the individual's experience. They are all stages in the transition from adolescence to full adult life with its new interests and responsibilities and changed social groupings. It is natural that as young men and women pass from the teens to the twenties life should centre down, becoming focused, particularly perhaps for the woman, on marriage and parenthood, but this should not mean a complete withdrawal from cultural and community life. Moreover, there are those who remain single, and who must find scope and status in the adult community if they are not to remain permanently immature, or become withdrawn or embittered. Where the young adult is already linked through family tradition or through his youth club with an adult organisation he can pass naturally and easily from the youth to the adult group. In other cases a break and restart must be made. In some parts of the country 'Eighteen-Plus' groups for young men and women aged between eighteen and thirty have been formed, but they are few and their future is doubtful.[1] When once adolescence has passed, groupings are no longer primarily based on age, but are formed on a community or interest basis, and these will be discussed in another chapter.[2]

The developments just described are indications of the overall vitality of the youth movement and its possibilities for growth, but the movement has its shortcomings and failures. As is inevitable in so diversified an enterprise, there are wide variations in standards. The work done by some units is very good indeed, showing initiative and imagination as well as enthusiasm and persistence, but others are content with limited aims and low standards of achievement.[3] Many organisations are contending with serious difficulties such as inadequate and unsuitable premises, shortage of funds and difficulties in obtaining equipment, but grave as these difficulties may be, they are not as serious a handicap to a club's progress as limited vision and lack of enterprise on the part of its leader. It is the quality of its leadership more than any other factor which will determine the success or failure of the youth service, and this is true not only of its individual units, but of the movement as a whole. 'In the long run the youth service will stand or fall not by the magnificence of the premises provided by Church or Local Education Authority or by the generosity of the Ministry of Education, but by the degree to which men and women of ability and goodwill are prepared to give themselves in friendship to

[1] L. Gordon Home, 'What are Eighteen-Plus Groups?', *Social Welfare*, Vol. VI, No. 12, October 1947, p. 346.

[2] Chapter XX, 'Settlements and Community Centres'.

[3] See Margaret G. Allen, *A Survey of Mixed Clubs*, National Association of Girls' Clubs and Mixed Clubs, 1948, for examples.

young people.'[1] There is, unfortunately, a real shortage of good youth leaders, both professional and voluntary, and considerable thought has been given to possibilities of further recruitment and training. This is a problem which presents serious difficulties, however. Professional youth leadership involves exacting work at awkward hours, the financial rewards are not great, and it is not generally regarded as a profession in which one should spend the whole of one's working life. Hence, men and women interested in young people are more likely to be attracted by one of the many alternative openings in social and educational work. The possibilities of interchange between youth leadership and related professions such as teaching and the youth employment service are being explored,[2] but a satisfactory solution to this problem has not yet been reached.

Since membership of a youth group is voluntary, a matter of choice, one indication of the extent to which any youth organisation is meeting the needs of the young people in the area in which it is situated, is the extent to which they are attracted by it, and having sampled what it has to offer, remain in it. It is true that many young people are 'unclubable' because they have interests or hobbies of their own and are adverse to group activities, but there are others who appear to be in need of the companionship and occupation which a good club has to offer, but who fail to find their niche in any particular organisation. One of the most disturbing findings of the Birmingham survey was that a great many of the boys and girls found to be unattached to any organisation were in fact lapsed members[3] and the reasons given for their lapse are equally disturbing, since it appears from the answers given that 'Many of these young people believe, rightly or wrongly, that uniformed organisations cater primarily for children, and that clubs on the whole are badly organised, that they don't do anything and that attendance is "a waste of time".[4] It may be argued that these answers reflect the cynicism and restlessness of the adolescents themselves, and do not necessarily indicate that the club activities thus scornfully rejected are inadequate. Nevertheless, there are clubs to which the indictment applies, since the programme has become stereotyped, the activities are conducted in a rather colourless and unimaginative way and the leader excuses herself from further efforts to introduce new ideas or raise existing standards on the grounds that 'the members don't want it'.[5]

[1] Reed, op. cit., p. 163.

[2] See, for example, the Report of the Committee on the Recruitment, Training and Conditions of Service of Youth Leaders and Community Centre Workers, Ministry of Education, 1949.

[3] Reed, op. cit., p. 127. [4] Ibid., p. 129. [5] Margaret G. Allen, op. cit.

Attracting tough young gangsters to a club and turning their aggressiveness and overflowing energy to good account is a task only matched in difficulty by that of rousing interest in the apathetic and oversophisticated. It is easier to go on quietly year after year catering for a limited group of orderly if less enterprising young people than to attempt these tasks, but those who have had the courage and persistence to undertake them have shown that the young people will respond if the right approach to them can be found. Not everyone has the type of personality suited to this work however, nor should the needs of the quieter or more earnest boys and girls be neglected in trying to meet those of the toughs. In each area a wide variety of youth clubs and centres is needed to cater for the infinitely diversified types of young people living there. Moreover, whatever the activities carried on or the type of boy or girl attracted, the atmosphere in each club should be friendly and welcoming, and there should be a sense of purposeful activity combined with a readiness to explore and experiment, which will help the young people to feel that club membership is a worthwhile and joyous adventure, through which they can come to a better understanding of the meaning and purpose of life, and grow into mature men and women.

PART FOUR

THE AGED AND HANDICAPPED

'How we treat our old people is a crucial test of our national quality. A nation that lacks gratitude to those who have honestly worked for her in the past, while they had strength to do so, does not deserve a future, for she has lost her sense of justice and her instinct of mercy.'—DAVID LLOYD GEORGE.

'Sickness is a hindrance for the body, but not for the will.'—Saying of a Roman slave quoted by FREDERICK WATSON in *Civilization and the Cripple.*

CHAPTER XVII

THE WELFARE OF OLD PEOPLE

COMMUNITY care for the aged is complementary to community care for children, and the welfare of old people, like that of children, is becoming increasingly a national as well as a family responsibility. The extent of the nation's commitments in this direction is likely to increase still further in future, both because of the growing number of old people in the population as compared with those of working age, and because of a wider conception of what constitutes their care.

A fall in the birth-rate, which with minor fluctuations continued from the seventies of the nineteenth century to the thirties of the twentieth, has combined with an increasing expectation of life to alter the age structure of the population very markedly. Between 1871 and 1947 the number of people over sixty-five in Great Britain increased fourfold, and the Royal Commission on Population estimates that even if future mortality shows no reduction on present levels this number may be expected to grow from approximately 5·0 million in 1947 to 7·3 million in 1977.[1] With few exceptions old people consume more than they produce, and provision for their adequate maintenance is likely therefore to be a serious drain on the resources of the community. Hence the importance from the national, as well as from the individual's, point of view of all measures, both social and medical, to ensure that an increased expectation of life will mean an increased length of active life as well as greater length of days.

One of the most important issues arising out of this situation is that of the employment of the elderly. A nation struggling for economic survival urgently needs productive work from all fit persons, while opportunities for continuing in useful and congenial work are likely to further the health and happiness of many older people. Dr. J. H. Sheldon, who in 1945 conducted a survey of the health and well-being of a sample of old people in Wolverhampton, even goes so far as to suggest that one reason why old women

[1] Cf. Report of the Committee on the Economic and Financial Problems of Provision for Old Age. Cmd. 9333, 1954. During this same period the percentage of persons of working age is expected to fall slightly from 64 per cent to 62 per cent of the total population.

live longer than old men, in spite of greater physical disabilities, is that as long as they are able to get about at all they can generally find an interest and purpose in life related to their previous home-making duties. On the other hand, an elderly man whose life has centred round his employment is lost when he retires, and unless he can find some fresh interest may proceed to die slowly of boredom.[1] It was found during the war that many men were capable of useful work long after the usual retirement age, and that, particularly in the case of skilled workers, the quality, if not the quantity, of their work compared favourably with that of younger men.[2] Research into the effects of ageing on speed and accuracy in a number of differing skills, and on learning and memory processes, is being carried out by the Department of Psychology, Cambridge University, with the help of a grant from the Nuffield Foundation, and the first Report on this work, *Skill and Age*, issued in May 1951, confirms that while older people find it harder to adjust themselves to new demands, and are less able to cope with time pressure, on familiar work not subject to such pressure they retain their skill to a late age.[3]

The issue of the retention of older men and women in employment is a complicated one however. Workers in heavy industries who have been subject to considerable physical strain throughout their working lives are unlikely to be sufficiently fit to carry on beyond the present pensionable age, but the amount of light work available is limited. In managerial and professional work the claims of the young and middle-aged, who may be debarred from promotion and wider experience by the retention of senior colleagues after normal retirement age, must also be considered. A fuller and happier life for the elderly should not be purchased at the expense of the frustration of the young. It is sometimes suggested that this difficulty could be overcome if elderly workers were willing to change over to less onerous jobs or part-time work when they reached retirement age. This might mean acceptance of a lower status as well as reduction in income, and would be a difficult adjustment for an elderly person to make, but it might be preferable to enforced idleness. The imposition of a compulsory retirement age by a number of firms, and by central and local government departments, precludes experiments along these lines, and less rigidity would seem to be desirable in the interests of both nation and individual. This was emphasised in the First Report of the National Advisory Committee on the Employment of Older

[1] J. H. Sheldon, M.D., F.R.C.P., *The Social Medicine of Old Age*, Nuffield Foundation, 1948, pars. 242 and 243, pp. 191–3.
[2] The Nuffield Foundation, Fourth Report, 1949, p. 66.
[3] Ibid., *Skill and Age*, 1951.

Men and Women, published in October 1953. The Committee was set up by the Minister of Labour 'to advise and assist him in promoting the employment of older men and women'. It recommended that all men and women employed in industry, commerce, the professions or elsewhere who can give effective service, either in their normal work or any alternative work which their employer can make available, should be given the opportunity, without regard to age, to continue at work if they so wish. The attitudes of the workers are shown in a Ministry of National Insurance survey. Four out of every ten men in the sample gave up work at 65, their main reasons being employers' action (28 per cent) and ill-health including strain (25 per cent). 25 per cent were chronically sick. Those who remained did so because of financial need (45 per cent), or they felt fit (25 per cent) or preferred to work (20 per cent).[1]

Most discussions on old people's welfare count as old people men and women of 'pensionable age'—that is, men of sixty-five and over, and women of sixty and over, and thus include within their scope people of widely differing ages and degrees of infirmity. The needs and outlook of a hale and hearty man in his late sixties or early seventies, possibly capable of some years of work, and almost certainly able to live independently and take an active part in community life, are very different from those of an infirm or senile person of eighty or more needing hostel or institutional care. Moreover, old people form a cross-section of the whole population, and include persons of differing family backgrounds and economic and social circumstances, and they cannot be considered apart from the families and local communities to which they belong. Thus Dr. Sheldon emphasises over and over again that old people, whether they actually live under the same roof as their children and relatives or not, regard themselves, and are regarded, as members of the family, and that any plans made for the well-being of the elderly must take this into account. He also shows that this family tie, though not willingly or easily broken, may impose serious strains both on the old people themselves, and on the younger relations who care for them, and emphasises that the community should make itself responsible for easing this burden wherever possible. For example, the provision of short-stay homes would be a great boon, and this has been made in some areas.[2] Moreover, while the family tie should be preserved where it exists, the needs of those who have no one to whom they can turn for comfort or support, either because they have outlived their rela-

[1] Reasons given for Retiring or Remaining at Work. Report of an Enquiry by the Ministry of Pensions and National Insurance. H.M.S.O. November 1954.

[2] J. H. Sheldon, *The Social Medicine of Old Age*, 1948, ch. v, pp. 140–64, also pp. 195–8.

tives, or have become estranged from them, must not be overlooked. These old people, like the children deprived of home care, have a special claim on society.

For the purpose of this discussion of the provisions which are made for their welfare old people may be divided into three groups: those still able to live independently in their own homes, though perhaps needing special forms of community care; those who require residential care but not nursing; and the sick and infirm.

The first claim on the community made by old people who desire to live independently is for adequate retirement pensions, so that they can live in reasonable comfort free from financial anxiety, and without imposing an undue burden on their children or other relatives. The provisions of the National Insurance and Assistance Acts were designed to ensure this, but at present their effectiveness in securing freedom from want for old people is being threatened by the rising cost of living, which makes it very difficult for pensioners with no other resources to make ends meet. This is recognised by the successive increases in both retirement pensions and assistance grants made since 1948. Statutory provision is sometimes supplemented from voluntary funds, but these, useful as they may be in helping individuals in special need and belonging to special categories, are limited in both scope and amount. Ancient endowed charities providing tiny doles for the aged poor may even create difficulties for their administrators, and the Nuffield Foundation Survey suggested that steps should be taken to divert the money to more useful purposes. The law and practice relating to charitable trusts has been investigated by a Committee under the chairmanship of Lord Nathan. It reported in December 1952, and recommended that the cy-près doctrine, under which it is impossible to change the purposes of a trust until they have become impossible of execution, should be relaxed, while preserving the spirit of the intention of the founders.[1]

Suitable living accommodation is almost as important to old people as economic security, and in some areas is very difficult to secure. The Nuffield Foundation carried out sample surveys into the living conditions of old people in a London borough, Wolverhampton, Mid-Rhondda and Oldham, and many examples of distressingly bad conditions were revealed. The Survey Committee concluded, however, that 'it would on the whole be wrong to assume that old people are worse housed than the average of their class, and the many cases quoted of bad housing conditions are a criticism of the general housing conditions in the areas investigated

[1] Report of the Committee on the Law and Practice relating to Charitable Trusts. Cmd. 8710. 1952. [2] Ibid., p. 37, par. 92.

rather than an indication that old people occupy an unduly high proportion of unsatisfactory houses'.[2] At the same time, conditions which can be tolerated by the able-bodied impose an intolerable burden on the old and feeble. Here we have an example of the difficulty of balancing the claims of different sections of the population, as the housing needs of old people must be considered in relation to those of married couples with young families. The two claims do not always conflict, however, as there are many old people living in houses which are too big for them, and the provision of more flats and bungalows for the elderly may well release more accommodation for the use of families.

The statutory provision of a sufficient number of new houses is unlikely for some years, and some voluntary organisations and public utility companies in different parts of the country are doing what they can to relieve the shortage by the conversion of old houses into flats. Efforts of this kind can only touch the fringe of the problem and are no substitute for the discharge of what is essentially a public responsibility, but they have been a boon to many old people, and show what can be done by goodwill and ingenuity. Meanwhile the needs of the aged should be borne in mind by local authorities when preparing their housing plans. They may learn a great deal from the small-scale experiments which are now all that is possible, and from the surveys which have been and are being undertaken into numerous aspects of the housing of old people. For example, Dr. Sheldon, as a result of his inquiry, discovered that in 192 subjects, about 40 per cent of his sample, the happiness and domestic efficiency of the old person depended to a greater or lesser degree on the accessibility of children or other relatives,[1] a discovery which is of great importance in connection with the siting of old people's dwellings. Other matters which affect the happiness of elderly people are proximity to neighbourhood facilities such as shops, churches, cinemas and the public library; the number and types of rooms required; the sorts of labour-saving devices most helpful to the aged; and methods of housing management.

Financial security and suitable accommodation are fundamental to old people's welfare, but by themselves they are insufficient to ensure comfort and happiness in old age. This was recognised officially when supplementary pensions were introduced in 1940, for the relevant Act required the Assistance Board, which was to administer the scheme, to discharge its duties 'in such a manner as may best promote the welfare of pensioners'. The Board and its officers endeavoured to carry out this responsibility conscientiously, and in so doing collected a great deal of informa-

[1] Op. cit., p. 156, par. 203.

tion about the conditions under which old people live, and about their social as well as their material needs. Its conclusions as to the needs of old people are discussed in some detail in its Report for the year 1944. The Board's contacts were confined to those old people in receipt of supplementary pensions, but the Report points out that these are a cross-section of the aged. The great majority of pensioners were found to be 'hale and hearty, competent to manage their own affairs, and fully able to take a lively interest in the community around them', but help with personal problems was needed in many cases especially among the older pensioners, aged eighty and over, living alone. These problems were very varied, but the majority fell under three main headings, 'health, housing and the less tangible but very real problems arising out of a solitary existence'. Further, it was noted that, 'Many of the problems derive from the fact that old people are apt to find the pace and complications of life in a mass mechanised society too much for them'.[1] Hence the need of unhurried listening, wise counsel, and patient friendliness on the part of all who seek to help them.

The plight of the solitary old people who have no family ties and find loneliness the greatest burden of old age is stressed by all who have experience of welfare work for the elderly, and much thought is being given to the ways in which this can be alleviated. In many areas friendly visiting is undertaken by such organisations as the Red Cross or Toc H, or organised by the local Old People's Welfare Committee. The value of this work is recognised, and the need for its extension and co-ordination emphasised in a circular issued by the Ministry of Health in January 1950.[2] This circular draws attention to the contribution which the payment of regular friendly visits to old people in their own homes can make towards mitigating their loneliness, and ensuring that their needs are made known to the appropriate statutory and voluntary organisations best able to meet them. This is work which can well be done by volunteer workers in a spirit of 'good neighbourliness', but it needs organising and co-ordinating, and linking up with other forms of welfare work for old people. This co-ordination is something which an active and representative Old People's Welfare Committee is well fitted to undertake, as its membership is likely to include representatives of, and observers from, different departments and organisations closely connected with such work, for example, the National Assistance Board, the Social Welfare Department of the local authority, and the churches.

Friendly visiting is one way of mitigating the loneliness of old

[1] Report of the Assistance Board, 1944, p. 9.
[2] Ministry of Health Circular 11/50, *Welfare of Old People.*

people. Another is by means of the clubs which have been started in several centres of population. They vary widely in character, ranging as they do from weekly or monthly socials held in church halls or other hired buildings, to centres opening daily and offering a wide variety of facilities; from spontaneous self-governing groups, such as the Sons of Rest in the Birmingham area, who meet in pavilions lent by sympathetic Parks Committees, to elaborately organised and equipped clubs such as the Darby and Joan Club at Streatham. The success which has attended these clubs, even those functioning under difficult circumstances and in unsuitable premises, testifies to the fact that they meet a real need, and the work they do received tangible recognition in the National Assistance Act, 1948, as this empowers local authorities to make contributions to the funds of voluntary organisations whose activities 'consist in or include the provision of recreation or meals for old people'.[1]

Friendly visits and clubs are two ways of helping old people, but they are not the only possible ones, and attempts are continually being made to meet other needs. Domestic help can now be provided by local authorities,[2] but the shortage of workers and the cost to the authority of providing a really adequate home help service, help to make many schemes less effective than they might be. In some areas 'Meals-on-Wheels' are provided, often with the help of the W.V.S. and the British Red Cross, for old people who have inadequate cooking facilities, and are too infirm to go to a club or canteen. These schemes are expensive, but where it has been possible to run them they have been found to be very valuable, not only because of the nourishing food provided for old people who would be unlikely to obtain it in any other way, but because of the close contact maintained with housefast old people whose needs might otherwise be overlooked. Like the clubs, the 'Meals-on-Wheels' services can be and sometimes are grant-aided by local authorities. Other services provided in one or two areas are a chiropody service, and a rota of sitters-in, while, as already noted, a few Old People's Welfare Committees have holiday houses or schemes whereby the old people can obtain holidays in hotels or in guest houses at reduced rates in the off-seasons.

It is generally recognised that the majority of old people prefer to remain in the general community, living their own lives in their own homes, as long as possible, and this independence should be encouraged in every possible way, but the time may come when

[1] National Assistance Act, 1948, Section 31.

[2] Under the provisions of the National Health Service Act, Section 29, described in Chapter V, above.

increasing infirmity makes independence impossible, or loneliness renders it intolerable. The commmunity thus has a responsibility for ensuring that residential accommodation is available for the aged who need it, and that it is so planned that the residents are given comfort and friendly care, and are enabled to enjoy the maximum possible degree of freedom and self-respect.

Until 5th July 1948, the local Public Assistance Committees were responsible for the residential care of the aged in their areas. Unfortunately these Committees inherited from their predecessors, the Boards of Guardians, the large mixed workhouses of the nineteenth century, institutions designed to deter all but those in desperate need from entering, and which were regarded with horror by the self-respecting poor who dreaded old age and infirmity, knowing that, failing relatives able and willing to care for them, they must end their days there. Of recent years local authorities have made real efforts to improve these institutions by the introduction of amenities and the relaxation of rules, but the design of the buildings, the large numbers to be accommodated, and the necessity of accepting all comers, however unpleasant their habits, have combined to slow down improvements. It is now generally recognised that, except for the minority needing professional nursing or really strict discipline, small homelike hostels are to be preferred to large institutions. For some years now voluntary organisations, both religious and secular, have provided small homes where personal, loving care is given to the residents. In this way these organisations have not only brought considerable happiness to the old people whom they have accommodated, but by their example have helped to raise the general standard of residential care for all old people throughout the country.[1] Certain local authorities had also experimented along these lines before 1939, and the evacuation hostels established during the war both by voluntary organisations and under the auspices of the Ministry of Health further demonstrated the advantages of small hostels.

The position with regard to residential accommodation for old people has been improved by the provisions of Part III of the National Assistance Act, for although owing to current shortages it is likely to be many years before the local authority institutions

[1] The Nuffield Foundation Survey Committee calculated that in 1944 national religious organisations maintained 98 homes in Great Britain, accommodating 6,203 persons, while returns from 86 per cent of the secular charitable organisations concerned with the work showed that 2,749 aged persons were accommodated in homes maintained by 120 different organisations. The number accommodated in P.A. Institutions and other Local Authority Homes, England and Wales, on 1st May 1946, was 62,957, or 1·16 per cent of the total population of pensionable age. *Old People*, pars. 153 and 193.

of to-day will be entirely replaced by 'Homes or Hostels designed to meet the varying needs of the persons concerned' envisaged by the framers of the Act, nevertheless the residential care of old people can now be planned on sound and humane lines which will safeguard the dignity and self-respect of those who seek it.

According to the Act accommodation is to be available for all persons 'who by reason of age, infirmity or any other circumstances are in need of care and attention not otherwise available to them',[1] whatever their means or social class. It is to be paid for by the user according to his means, but a pensioner retains a part (in 1955 7s. 6d.) of his pension for pocket money. The aims of the provisions of the Act with regard to accommodation are that 'the local authority will cease to be merely a reliever of destitution, and will become the provider of comfortable accommodation with care and attention for those who, owing to age and infirmity, cannot wholly look after themselves'.[2] Further, the Act empowers local authorities to arrange with voluntary organisations for the use of accommodation in hostels provided by them, payments being made at agreed rates; while a useful clause[3] ensures at least a minimum standard of care to all old people living in hostels or homes, by requiring that all homes for old people whether managed by voluntary organisations or by private individuals, shall be registered and inspected. Since the passage of the Act both local authorities and voluntary organisations have established a number of such hostels,[4] but these numbers are still insufficient to meet the need in all areas.

Among the most serious problems of old age are increasing infirmity and recurrent or chronic sickness. 'With advancing years the margin between sickness and health narrows', the burden on relatives who are caring for the old person increases, independent existence becomes less possible, and even the domestic care given by the hostels is no longer adequate. The placement and care of the infirm has proved to be the most intractable of all old peoples' welfare problems, and the position is still very unsatisfactory. This is due in large measure to the division of responsibility between the

[1] National Assistance Act, 1948, Section 21 (a).

[2] Summary of the Provisions of the National Assistance Bill, Cmd. 7248, 1947.

[3] Section 37.

[4] At a conference on 'The Care of Old People', held in 1949, Sir William Douglas said that since the end of the war local authorities had opened 155 small homes providing for about 4,800 people, a further 273 homes had been purchased and were being adapted, proposals for a further 164 had been submitted to the Ministry. At 31st July that year 637 homes were being operated by voluntary organisations. National Old People's Welfare Committee, Progress Report, 1949–50, pp. 13–14.

Regional Hospital Boards and the local authorities. If the old person is 'sick' the hospital board is responsible for his care; if only 'in need of care and attention', the local authority. But the line of demarcation cannot be defined with any exactitude, and while the authorities are arguing which of them shall take responsibility in any particular case the old person may remain uncared for. The Manchester firewood-seller who, after being turned away from hospital because he was not sick, and from a local authority reception centre because he was, returned home to die,[1] is not the only victim of this administrative dichotomy, and the position is causing grave concern to all interested in the welfare of old people.[2] In some parts of the country voluntary organisations, assisted by the National Corporation for the Care of Old People or King Edward's Hospital Fund, are providing 'half-way homes' which will take both long-stay cases of prolonged infirmity and short-stay convalescents who at the expiration of a period in hospital are still not fit to return to their homes or to a hostel for able-bodied old people. Even the promoters of such schemes have sometimes been held up by arguments as to which authority shall be responsible for which particular type of case. We still have a long way to go before we have a unified service which ensures 'that all old people whether in sickness, health or on the borderline between the two can receive without delay or argument as to whose responsibility they are, the treatment and care which they need'.[3]

Progress towards the goal of comprehensive and co-ordinated provisions for old people everywhere has been accelerated by the efforts of the National Old People's Welfare Committee to secure co-operation between the various statutory and voluntary organisations concerned. This committee was established under the auspices of the National Council of Social Service in 1940, Miss Eleanor Rathbone being the first chairman. Since its formation it has consistently encouraged the establishment of local and regional committees, whose objects are to co-ordinate the work in their

[1] See the correspondence in *The Manchester Guardian* during the first fortnight of January 1951.

[2] The National Old People's Welfare Committee was so anxious that something should be done to improve matters that it arranged for a deputation to wait on the Minister of Health (then Mr. Aneurin Bevan). The Minister received the deputation on 17th May 1950, and promised to give consideration to the points raised, but he seemed to think that there was 'no statutory lacuna', and that the difficulty might be dealt with by 'sensible administration'. National Old People's Welfare Committee, Progress Report, 1949–50, Appendix A.

[3] Second Annual Report of the National Corporation for Old People for the year ended September 1949.

areas and promote new ventures where these are needed, and in July 1950 there were 34 County and 510 local Old People's Welfare Committees in Great Britain and Northern Ireland. As well as promoting local effort the National Committee acts as a clearing house for information about old people's welfare and is consulted by government departments and voluntary organisations, as well as by interested people from abroad.[1]

The National Corporation for the Care of Old People was founded in August 1947, with the assistance of a generous grant from the Nuffield Foundation, and a substantial sum from the Lord Mayor's National Air Raid Distress Fund. It was constituted to meet the need for a central body 'able not only to make grants to schemes for the welfare of old people, but also to accept gifts and hold property on trust, to obtain and maintain an expert advisory and consultant service and to set up a central record of needs and provisions'.[2] It has already done much useful work along these lines. During the first two years of its existence it made numerous grants towards the provision of residential homes for able-bodied old people, and it is now devoting the greater part of its resources to assisting voluntary organisations in their efforts to make provision for the infirm. It sets out not to replace but to reinforce the work of voluntary agencies seeking to further the welfare of old people, and to complement rather than compete with the National Old People's Welfare Committee. Together these two agencies can do a great deal to encourage statutory and voluntary bodies to make further constructive efforts to meet the many and varying needs of the elderly and aged, and to grapple with the problems of an ageing population.

[1] For accounts of its work see the annual reports of the National Council of Social Service; also National Old People's Welfare Committee, Progress Report, 1949–50.

[2] Nuffield Foundation Third Report, year ending 31st March 1948, p. 54.

CHAPTER XVIII

THE PERMANENTLY HANDICAPPED

THE most important social aspects of disablement are the impairment of function which it entails, and the extent to which it prevents the disabled person from leading a normal life as an economically independent and socially integrated member of the community. Severe disablement means that the handicapped person becomes at the same time more dependent on, and yet isolated from, his fellow men, and this combination of dependence and isolation, together with the frustration accompanying his inability to make full use even of those powers which remain unimpaired, may easily lead to resentment and suspicion, or, what may be even harder to combat, apathy and despair. The aim of rehabilitation is to enable the disabled person to overcome his physical handicap and psychological difficulties as far as possible, and to take his place as a self-supporting and self-respecting member of the community, able to share in both its economic and social life.

The use of the term rehabilitation is, in itself, evidence of the acceptance by the community of a new and constructive approach to the problem of the handicapped. This found expression in the legislative and administrative action culminating in the setting up of the Inter-departmental Committee on the Rehabilitation and Resettlement of Disabled Persons,[1] and the embodiment of its recommendations in the Disabled Persons (Employment) Act, 1944. Such action was speeded up by the necessity of utilizing all available man-power, however unpromising, in the prosecution of the war, and by the desire to give the disabled ex-service man the maximum opportunities for recovery and resettlement, but, largely owing to the constructive approach of their framers, these wartime measures have become the basis of a permanent scheme.

The scope of the scheme is wide. A disabled person, as defined by the Act, is 'a person who, on account of injury, disease or congenital deformity is substantially handicapped in obtaining or keeping employment or in undertaking work on his own account

[1] Cmd. 6415/43. The Committee met under the Chairmanship of Mr. George Tomlinson and its report is frequently referred to as the Tomlinson Report. 'Rehabilitation' used in this connection means the restoration of the worker to working capacity; 'resettlement' his re-establishment in work.

of a kind which apart from that injury, disease or deformity would be suited to his age, experience and qualifications'.[1] This covers disablement of all kinds and causes, surgical, medical and psychiatric; disablement dating from birth as well as that brought on in later life by war service, disease, accident or industrial injury. Figures published in the Second Report of the Standing Committee on the Rehabilitation and Resettlement of Disabled Persons give the number of registered disabled persons on 19th April 1948 as 877,780, of whom 42·7 per cent were suffering from surgical disabilities, 34·9 per cent from medical conditions such as rheumatism, heart disease and pulmonary tuberculosis, and 5·7 per cent from psychiatric disorders, while the remaining 16·7 per cent included the blind, the deaf and persons with congenital malformations. Since registration is voluntary, and is made with a view to employment, these figures do not represent the exact proportions of handicapped persons in each group, and the discrepancy is likely to be higher in some groups than others,[2] but they give some indication of the scope of the scheme and the differing types of disablement covered by it.

If rehabilitation is to be really effective, it must be a continuous process, starting in the earliest stages of treatment, and not regarded as complete until the disabled person has adjusted himself to a life as nearly normal as his disability will allow. It thus demands the close co-operation of many different agencies, medical, social and industrial, statutory and voluntary, and not least from the family, friends, employers and work-mates of the disabled person. Further, while general provisions may be made to meet the needs of all handicapped persons, rehabilitation to be really successful involves the individual treatment of each patient, and depends ultimately on his understanding and co-operation.

From the point of view of their final resettlement, the disabled may be divided into three main groups, those who with special training, and if necessary mechanical aids, can be found employment alongside normal persons, and successfully hold down the jobs they obtain; those who, while they are unable to stand up to ordinary working conditions, can be usefully employed under sheltered conditions in special workshops; and those who owing either to the exceptional severity of their disablement, old age or some other complicating factor can never become self-supporting

[1] Op. cit., Section 1 (i).

[2] Of the blind persons in England and Wales at 31st March 1949, 44·5 per cent were seventy and over, and a further 11·3 per cent between sixty-five and seventy, i.e., more than half the blind persons in this country are over working age and would not register for employment. The figures are taken from the Report of the Working Party on the Employment of Blind Persons, H.M.S.O. 1951.

and may need continuous care and attention. War-time experiments in the employment of disabled persons showed that quite severely handicapped people could, given the proper training and conditions, successfully engage in industrial work hitherto thought beyond their powers, and so added considerably to the proportion of the disabled in the first group, that is those who are regarded as capable of being trained for normal work in selected occupations. This should be encouraged wherever possible, as work alongside normal people not only enables the disabled person to be economically independent, but assists him to make a better general adjustment. This is emphasised by the Working Party on the Employment of Blind Persons, which states 'One of the most desirable consequences of placing a blind worker in factory employment is that his social horizon is immeasurably extended. He is able to partake in social activities . . . and meet people with whom he has interests, and not only blindness, in common.'[1]

Provisions to further the rehabilitation of those handicapped persons likely to make good in normal work include preparatory therapy and training in hospital; industrial rehabilitation courses to tone up and test the aptitudes of those who cannot benefit from vocational training without such preliminary help, and vocational training in a number of trades. This may take place within industry, at a Ministry of Labour rehabilitation or training centre, or, for the seriously disabled, at a special residential centre such as St. Loyes' College for the Training and Rehabilitation of the Disabled, Exeter, or Queen Elizabeth's Training College, Leatherhead. There are also rehabilitation centres for workers in certain specialised employments such as the Miners' Rehabilitation Centres under the auspices of the Miners' Welfare Commission, and the Seamen's Rehabilitation Centre at Summerlands, near Kendal.

In the past, employers have not always been willing to take on disabled persons, fearing that they might not be able to work as efficiently or effectively as those whose faculties are unimpaired, and consequently the handicapped have found some difficulty in obtaining suitable work. The Disabled Persons (Employment) Act, 1944, endeavours to facilitate the entry of the handicapped into employment by instituting a scheme for the registration of disabled persons, and by making it obligatory for employers of twenty or more workers to engage a percentage (at present 3 per cent) of disabled persons. The Act also makes it possible for the Ministry of Labour to designate certain employments as especially suitable for disabled persons, but as such designation may give the impression that the disabled are, in the main, only fit for compara-

[1] Op. cit., p. 45, par. 104.

tively low-grade work, these powers have been used with extreme caution, the only employments which have been so designated up to the present being those of passenger electric-lift attendant and car-park attendant.

Employment under sheltered conditions is provided for the severely disabled by the Disabled Persons Employment Corporation, a non-dividend-paying corporation set up by the Ministry, which has established 'Remploy' factories in different parts of the country. Here the severely handicapped work at their own pace at specially selected light trades and are assured of a steady job and wage. The products are placed on the commercial markets. Voluntary undertakings of a similar nature, such as the Papworth Village Settlement for sufferers from tuberculosis and the Lord Roberts Memorial Workshops receive financial assistance from the Ministry, which may also grant aid to local authorities who are providing sheltered employment in special workshops for disabled persons.[1]

The provisions made for industrial rehabilitation and resettlement are thus extensive and varied, but if the disabled person is to take full advantage of them he needs individual help and guidance, which will take into account his temperament and intelligence, his home circumstances and social and educational background, as well as the nature and extent of his disability. Since 1941 the Ministry of Labour has employed special officers—the disablement resettlement officers—to give this individual guidance, and the success of the resettlement schemes depends in large measure on the understanding of the individual, the knowledge of available facilities for training and employment, and the degree of co-operation with medical and social personnel also concerned with the case, shown by these officers.

The work of rehabilitation and resettlement is not easy. It has been hampered by the shortages which have delayed the setting up of training centres and Remploy factories, and by other difficulties. Among these is the difficulty sometimes experienced by the handicapped person in finding suitable accommodation. 'Residential accommodation is often the only real problem, but it may be a very difficult one. Relatives are often unable or unwilling to provide it, a landlady is seldom prepared to give the small amount of assistance needed, and the ordinary type of home for incurables is unsuitable. . . . The result is a devastating sense of frustration for the individual and a waste of valuable potential labour.'[2] The period after the disabled person has left college and

[1] They are usually Workshops for the Blind.

[2] Dame Georgiana Buller, who has been closely associated with Queen Elizabeth's Training College, Leatherhead, and St. Loyes' College, Exeter.

training centre and is endeavouring to adjust himself to home and work may also be very trying, and follow-up by a social worker, particularly in serious or difficult cases, is of great value when it is available.

So far disablement has been considered almost entirely as a problem of employment, and rehabilitation and resettlement as processes directed towards fitting the handicapped person for this, and ensuring that he obtains the type of work in which he will best be able to exercise the maximum skills of which he is capable. This is perhaps the most important aspect of community care for the disabled, but it is not all that is needed. The handicapped person must be integrated socially as well as economically with the normal community. This is difficult, and in his struggles to find a place in a world in which he is regarded as different from the majority of his fellows the disabled person needs encouragement and help. He may gain much from the support of his fellows similarly placed, from association with a group in which he conforms to type, and in which his difficulties are shared by all and taken as a matter of course. He may also need individual help and understanding from someone he has learnt to know and to trust, who understands his difficulties and hesitations, and helps to link him up with the normal community. The welfare associations for the handicapped endeavour to meet these needs, varying their techniques to meet the special problems of the categories of disabled persons with which they are particularly concerned. For example, Mr. J. D. Evans writes of the missions to the deaf: 'Few people realise what difficulties and humiliations face the deaf and severely deafened in their efforts to mingle with the hearing world; too often the deaf sink into themselves rather than face the task, and by so doing they tend to lose their lip-reading powers, their imperfect voices, and worse still, their psychological balance. From these evils the missionary centre affords protection. *It is at once the buffer between the deaf and the hearing world, and the gateway into that world.*'[1]

This work is not easy, for it requires sensitiveness to the physical and psychological difficulties of the many different types of disabled persons. There is, for example, the difference in outlook and problems of physical and psychological adjustment between the handicapped who are 'born that way' and those who have had experience of normal life before being disabled by disease or injury.

Quoted in Beveridge, *Voluntary Action*, pp. 257–8. The welfare powers of local authorities under Part III of the National Assistance Act, 1948, include the provision of hostels for disabled persons who are working or training for work. National Assistance Act, Section 29 (4) c.

[1] J. D. Evans, in *Voluntary Social Services in the Modern State*, ch. v, p. 78. Italics mine.

Thus Mr. Evans draws attention to the fundamental difference in psychological attitudes between the deaf (that is, persons either born deaf or deprived of hearing power so early in infancy that they never absorb a language in the natural imitative manner) and those deafened in later life. 'Between the psychological attitudes of the deaf and the deafened to the world in general', he writes, 'there is an almost unbridgeable gulf. . . .' 'At the beginning of their lives the deaf are abnormals shut off from that stream of verbally conveyed ideas which moulds the individual mind to general sameness with the mental pattern of society, and throughout their lives the deaf are struggling towards full normalcy. The deafened, on the other hand, are normals threatened with the horror of abnormalcy. To the change in their state, and particularly to the change in the behaviour of other people towards them, they are peculiarly sensitive—the least tendency on the part of the public to treat them as "different" from normals fills them with acute distress, in some cases, indeed, amounting to torment.'[1] Further, the disabled, like the old, are drawn from all sections of the community, they differ in age—although in certain categories, such as the blind and deafened, the higher age ranges predominate —intelligence, education, home background, and social class. The differing types and degrees of disablement also impose differing kinds and degrees of social isolation, so that, for example, the adjustment problems of the helpless and bed-ridden cripple are in many respects quite different from those of the blind or the deaf. There are, moreover, those, few in number but requiring very special care, who suffer from multiple handicaps, such as the deaf-blind, or the blind epileptics, and those who are both mentally and physically defective. If all these differing individuals and types are to be helped socially, there must be a wide variety of provision, and a deep imaginative understanding of individual needs.

Until the passing of the National Assistance Act, 1948, the social care of the handicapped was, in the main, left to voluntary effort, except for the provisions made for the education of handicapped children.[2] The only handicapped persons for whom there was statutory social provision were the blind. The social and economic handicaps suffered by this category of disabled persons can be readily appreciated, and in 1920, when the first Blind Persons Act was passed, the State assumed responsibility for devising means of minimising them as far as possible. This Act, which was strengthened by the Blind Persons Act, 1938, guaranteed a minimum standard of

[1] J. D. Evans, in *Voluntary Social Services in the Modern State*, ch. v, p. 78. The persons here described as 'deafened' are now officially designated the 'hard of hearing'.

[2] Described above, Chapter XII.

living to the blind by making blind persons eligible for non-contributory pensions at fifty (reduced to forty by the 1938 Act) and empowering local authorities to give relief to needy blind persons outside the Poor Law.[1] It also imposed on County Councils and County Borough Councils the duty of framing welfare schemes to meet the social needs of blind persons normally resident in their areas. Local authorities could either operate these services themselves or through the medium of a voluntary organisation, and in fact they varied considerably in this matter, as in the types of services provided. In most areas these included facilities for training and sheltered employment; home visiting and the teaching of Braille or Moon and handicrafts; and social and recreational centres. On the whole the partnership between statutory and voluntary services worked reasonably well, and the services provided were adequate to meet basic needs, but there were differences between different areas, and in some perhaps insufficient local realisation of the possibilities of training and employment for younger men and women outside a narrow range of a limited number of sheltered employments.[2] The fact that the majority of the blind are elderly and unemployable coloured a great deal of this kind of welfare work.[3]

Under the National Assistance Act the provision of welfare services for the handicapped becomes a local authority responsibility along with the social care of the aged. The intention of the Act appears to be to extend to all those who are permanently handicapped the services hitherto available for the blind alone, and to allow the same flexibility in the administration of the proposed general welfare schemes as had been allowed in blind welfare. Thus Section 29 empowers County Councils and County Borough Councils 'to make arrangements for promoting the welfare of persons who are blind, deaf or dumb, and other persons who are substantially and permanently handicapped by illness, injury or congenital deformity or such other disabilities as may be pre-

[1] The whole of this Act, and large sections of the Act of 1938, were repealed by the National Assistance Act, 1948. The National Assistance Board is now responsible for the financial assistance of the blind persons. See above, Chapter III.

[2] For a description of the statutory and voluntary provisions for the blind before and during the early years of the Second World War, see J. F. Wilson, 'Voluntary Organisations for the Welfare of the Blind', ch. iv in Bourdillon, *Voluntary Social Services in the Modern State.*

[3] The Working Party on the Employment of Blind Persons estimated that out of the total blind population of 87,175 approximately 36,400 are of working age, sixteen to sixty-five. Of these about 22,000 are 'unemployable', leaving about 14,000 capable of work. Approximately 11,000 are in employment or training for it, leaving about 3,000 capable of some form of work if the opportunity were there.

scribed by the Minister [of Health]'. This power becomes a duty 'to such extent as the Minister may direct', and he has already directed that the welfare of the blind is a duty. The local authority may employ a voluntary organisation registered under the Act as its agent for carrying out these provisions, and may contribute to its funds.[1] Thus the partnership between the local authorities and voluntary organisations developed in many areas in relation to the care of the blind, may, if the local authority so decide, and if suitable voluntary organisations exist, be extended to meet the needs of other handicapped persons.

The welfare provisions which local authorities are empowered to make by the National Assistance Act include, in particular, an advice service; accommodation in hostels for disabled persons employed in sheltered workshops or in work provided under the Disabled Persons (Employment) Act; 'home worker' schemes; assistance in marketing produce; recreative facilities; and—a very important basic provision—the compilation of classified registers of handicapped persons. The Ministry stresses that these provisions should be based on the recognition that the needs of disabled persons vary according to 'the nature of the handicap and the degree of personal adjustment which the individual has achieved or can expect to achieve', and should aim at ensuring that 'all handicapped persons, whatever their disability, shall 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.[2]

Since the passing of the Act, County Councils and County Borough Councils have been investigating conditions in their areas, appointing welfare officers and preparing and implementing schemes. Given imaginative understanding of the social and psychological needs of disabled persons, and willingness to co-operate on the part of both local authorities and voluntary bodies, the Act makes possible the development in each area of really constructive services for the permanently handicapped. But important as they are, these developments are local in character, and there is much which can only be done on a national scale. Hence the value of such national voluntary organisations as the National Institute for the Blind, the National Institute for the Deaf, and the Central Association for the Care of Cripples. These associations endeavour to maintain contact with all organisations in their particular field, watch over legislation affecting the cate-

[1] National Assistance Act, Section 30.

[2] Ministry of Health Circular 87/48, par. 60. See also Circular 32/51 which encourages local authorities to go forward with schemes for the handicapped.

gory of handicapped persons in which they are interested, and initiate and maintain special services which cannot well be provided locally. Thus the National Institute for the Blind, in addition to its general functions as a co-ordinating body watches over legislation concerning the blind, prints books, music and periodicals in Braille and Moon, maintains educational establishments for specially gifted and specially handicapped blind children, runs homes and hostels, including two hostels for the deaf-blind, and a Home of Recovery for the newly blinded, and helps to secure employment for the blind. Similarly the National Association for the Deaf endeavours, though not altogether successfully,[1] to bring about fuller co-operation between all organisations setting out to assist the deaf or the deafened, watches over legislation concerning the deaf and its administration (the association is very interested in the arrangements for the provision of hearing aids under the National Health Service Act), and maintains two homes for deaf women and a hostel for deaf lads between the ages of sixteen and twenty-one. The Central Association for the Care of Cripples concentrates principally on promotional and educational work, but there are other voluntary organisations whose benefits are not confined to cripples from particular areas.

On the whole, the outlook for the handicapped person of this generation is more hopeful than it was in times past, as the attitude of society towards him is changing from pity for his helplessness to encouragement to him to make the most of his powers. This change is coming about slowly, however, and much remains to be done to educate public opinion to a real understanding of the new approach.[2] Further, while doing everything possible for those who can be most readily assisted to attain a large measure of independence, we must not overlook the needs of those with multiple or very severe handicaps for whom little can be accomplished in the way of rehabilitation. However helpless they may be they are persons who have their lives to live, and they are entitled to patient and skilled social and psychological as well as physical care, so that they may achieve as great a measure of happiness as may be possible.

[1] This is brought out very clearly by Mr. J. D. Evans in the work previously quoted, pp. 78–91.

[2] 'In spite of recent advances in our knowledge of the real capacity of the blind for both work and pleasure . . . [mistaken ideas] . . . continue to be widely held and they tend to influence the approach to the blind from quite an early stage and in ways that are unfavourable to full and healthy development.' Report of the Working Party on the Employment of Blind Persons, p. 8, par. 7.

CHAPTER XIX

THE MENTAL HEALTH SERVICES

In the last chapter we were considering the difficulties which individuals handicapped by some more or less permanent infirmity have to overcome in order to achieve as great a measure as possible of economic independence and social adjustment, and the provisions made by the community to help them. The services described in that chapter, such as the disabled persons' register and the services of the disablement resettlement officers, are available to all handicapped persons, whether their disability be mental or physical, but those whose disablement is due to mental defect or disease present a special problem and need further legislation to safeguard their position and provide for their care. From the administrative point of view the crux of the problem is that mental illness or defect may, and in all but the less serious forms of illness does, involve either failure to achieve the understanding required of a responsible person managing his own affairs, or its loss either temporarily or permanently, and hence mentally defective or mentally sick persons usually require control as well as care, for their own sake and that of others. The imposition of such control, without the full understanding or consent of the person concerned, is a serious infringement of the liberty of the subject, and must needs be hedged about with adequate safeguards. The difficulties of framing laws which will provide these safeguards, while maintaining control, and yet will further rather than hamper the possibilities of early and effective treatment where this is possible, have proved considerable.

In considering the sociological and administrative problems resulting from the failure of individuals to achieve or retain full mental health, it is usual to distinguish between mental defect, or 'arrested or incomplete development of mind', and mental disease or disorder, in which the mind, possibly fully developed and of great intellectual capacity, fails to function normally, either temporarily or permanently. The two conditions may be found together, and Dr. A. F. Tredgold, one of the leading English authorities on mental deficiency, points out that defectives are more liable

to some forms of mental disturbance than non-defectives, although many of them remain completely stable throughout their lives.[1] Administratively and socially the two conditions present rather different problems however, and this difference between disease and defect has been recognised since the time of Edward I, when the distinction was made between the 'born fool' or idiot, and the lunatic or person who 'hath had understanding, but by disease, grief or other accident, hath lost the use of his reason'. Yet, in spite of this early recognition, it was not until the Idiots Act, 1886, that separate provision was made for the care of the two categories of persons.

The legal definition of mental defect or amentia in force at the present time is that contained in the Mental Deficiency Act, 1927.[2] Here it is stated to be a 'condition of arrested or incomplete development of mind, existing before the age of eighteen years, whether arising from inherent causes or induced by disease or injury'. The law goes on to sub-divide defectives so defined into three grades: idiots, imbeciles and feeble-minded, according to the degree of their abnormality. Those whose mental defect is so great that they cannot guard themselves against common physical dangers are graded as idiots, those able to do this but 'incapable of managing themselves or their affairs' form the imbeciles, or middle grade, while the feeble-minded, the highest grade of defectives, are in general more intelligent than the imbeciles or idiots, but still require 'care, supervision and control for their own protection and that of others'. The Act also recognises a fourth type of defective, the 'moral defective', in whose case there exists mental defectiveness coupled with strongly vicious or criminal propensities, and who require 'care, supervision and control for the protection of others', but very little use is made of this definition.

These definitions are based on social criteria, the defectives being graded according to their ability to make a satisfactory adjustment to their social environment and manage their own affairs, and in general the English conception of mental deficiency lays more stress on social adaptability as a measure of defect than on 'mental age' as determined by intelligence tests. For example the Interdepartmental Committee appointed by the Board of Education and the Board of Control to investigate the problem, concluded its preliminary discussion on the nature of mental defect by saying, 'In short, the only really satisfactory criterion of mental deficiency is the social one, and if a person is suffering from incomplete mental development which renders him incapable of independent social adaptation, and which necessitates external care, supervision

[1] A. F. Tredgold, *Mental Deficiency*, seventh edition, 1947.
[2] Section 1.

and control, then such a person is a defective'.[1] At the same time it is generally recognised that the grades of social defect recognised by British law correspond in general with 'mental age' as determined by modern methods of intelligence testing, so that a person with an I.Q. of about twenty or less is likely to have the characteristics of an idiot; an imbecile will probably be within the intelligence range of I.Q. twenty to fifty or fifty-five; and if a person's I.Q. is between fifty and seventy he is likely to be graded as feeble-minded.

While the Education Act of 1921 was in force some confusion was caused because this Act recognised a special class of mentally defective children, namely those children who were incapable of receiving proper benefit from education in the ordinary public elementary schools, but not incapable of receiving benefit from instruction in special classes or schools.[2] This legal recognition of a special type of 'educational defective', who might or might not be socially defective within the meaning of the Mental Deficiency Acts, was strongly condemned by the Wood Committee,[3] and was done away with by the Education Act, 1944, and its attendant regulations which group together as 'educationally sub-normal' all pupils who 'by reason of limited ability or other conditions resulting in educational retardation require some specialised form of education wholly or partly in substitution for the education normally given in ordinary schools'.[4] At the present time only those children whose mental handicap is so severe that they are incapable of profiting from education in special schools or whose combination of poor mentality and temperamental instability unfits them for such education come within the scope of the mental deficiency legislation.

The incidence of mental defect has twice been investigated during the last half-century, first by the Royal Commission on the Care and Control of the Feeble-minded, which reported in 1908, and, twenty years later, by the Joint Committee of the Board of Education and the Board of Control, which issued its report in 1929. Both the Royal Commission and the Joint Committee carried out careful investigations in selected areas, but whereas, as the result of its investigations, the Royal Commission estimated that the incidence of defect for the whole of England and Wales was 4·6 per 1,000 of the general population, the Wood Committee concluded that 'a conservative estimate of the mean incidence in

[1] Report of the Mental Deficiency Committee, 1929, Part I, p. 13. The Chairman of this Committee was Dr. Arthur B. Wood, M.A., C.B., and the Committee is therefore generally referred to as the Wood Committee.

[2] Education Act, 1921, Section 55 (1).

[3] Op. cit., Part II, par. 138, pp. 116–18.

[4] Ministry of Education, *Special Educational Treatment*, p. 71; see Chapter XII, above.

England and Wales as a whole would be about 8 per 1,000.[1] This discrepancy can be attributed in part to a more complete ascertainment in the later investigation, and Sir Cyril Burt estimates that with methods like those adopted by the Joint Committee the Royal Commission's figure would have been raised to almost 5·1 per 1,000,[2] but it cannot be wholly due to this, as the proportion of persons suffering from different grades of defect was very similar in the two enquiries,[3] and while it would be easy to miss a high-grade defective, this would hardly be possible in the case of an imbecile or idiot. Another factor tending to reduce the discrepancy between the findings of the two bodies was doubtless the decline in infant and child mortality which took place during the twenty years which elapsed between these investigations. Since mental defectives are often feeble in body as well as in mind this decline probably resulted in a greater proportionate reduction in defectives than in normal children, and Sir Cyril Burt considers that with the later rates of survival the Royal Commission's figures would have been still further raised to about 6 per 1,000.[4] Thus, a good deal of the difference in the incidence of defect noted by the investigators can be accounted for, but there remains a small 'real' increase which is not covered by these explanations, and which has caused a good deal of concern. Writing twenty years after the publication of the Report, Dr. E. O. Lewis, the Investigator for the Wood Committee, sums up the position, 'As the incidence even now is less than 1 per cent of the population, the increase of mental deficiency that has occurred during this last generation cannot be said to present a serious social problem of itself. But it becomes a "danger" signal if it indicates that the level of intelligence throughout the country has fallen.'[5] This question has been taken up by a number of authorities who have sought to discover what, if any, are the relations between intelligence and fertility, and whether or not the level of intelligence of the nation is declining. Somewhat differing conclusions have been reached,[6] but research is still going forward.

[1] Report of the Mental Deficiency Committee, Part II, p. 75.

[2] Memorandum on the Effect of the Differential Birth-rate on Inborn Characteristics presented to the Royal Commission on Population. Papers of the Royal Commission on Population, Vol. V, p. 66.

[3] Dr. Tredgold summarises the proportions as follows: Royal Commission, 76 feeble-minded to 24 imbeciles and idiots; Wood Committee, 75 feeble-minded to 25 imbeciles or idiots, *Mental Deficiency*, seventh edition.

[4] Ibid.

[5] Memorandum to the Royal Commission on Population on Relations between Intelligence and Fertility. Papers of the Royal Commission Population, Vol. V, p. 47.

[6] The views of a number of experts are given in Vol. V of the Papers of the Royal Commission Population, 'The Relation between Intelligence and Fertility', which was published in 1950.

The overall increase in the incidence of mental deficiency was one of the most important revelations of the Wood Committee, but equally significant were the discoveries made by Dr. Lewis as to its distribution. He ascertained that the incidence of defect was markedly higher in rural than urban areas[1] and the Committee attributed this to 'the selective migration of better stocks from the rural districts during the previous fifty years. This left behind a population of inferior mental quality who intermarried and produced a relatively large number of mental defectives.'[2] But this was not all, since the broad difference between urban and rural areas masked a marked unevenness of distribution within the areas. Mental defectives were frequently found in 'pockets'—groups of interrelated families in particular villages or neighbourhoods, and, with few exceptions, other members of these same families were found to be persons of poor mental endowment, if not actually certifiable.[3] Moreover, further investigation revealed that among the same group of families mental illness and epilepsy, certain physical defects and diseases such as tuberculosis and venereal disease, and social evils such as unemployability, pauperism, prostitution and crime were more prevalent than in groups of families not containing mental defectives. These discoveries led the Committee to the conclusion that there exists in the community a 'social problem group', comprising perhaps 10 per cent of the population, in which a large proportion of social inefficients are to be found, and to hazard the further suggestion that possibly 'mental deficiency, much physical inefficiency, chronic pauperism and recidivism are all more or less closely related, and are all parts of a single social problem' and 'poor mental endowment, manifesting itself in an incapacity for social adjustment and inability to manage one's own affairs, may be not merely a symptom, but rather the chief contributory cause of these kindred social evils'.[4] If this be so[5]

[1] Rural areas 10·49 per 1,000 total population. Urban areas 6·71 per 1,000 total population.

[2] Op. cit., Part II, p. 81.

[3] Dr. Lewis, Memorandum to Royal Commission on Intelligence and Fertility, Royal Commission Papers, Vol. V, p. 48. 'For every single mental defective there were usually three or more other members of the family who could be described as dull.'

[4] Report of the Mental Deficiency Committee, Part III, p. 39.

[5] This question is discussed at some length in a collection of essays edited by C. P. Blacker and published in 1937 under the title *A Social Problem Group?* Each contributor starts with a different medico-psychological or social condition such as mental disorder, prostitution or pauperism, and considers it in relation to the other problems discussed. Their findings are summarised by Mr. D. Caradog Jones, who after discussing the difficulties of the investigation and emphasising the need for further research, points out that one factor stands out conspicuously in these essays in association with one type of defect after another. This factor is sub-normality of intelligence, which need not be so serious as to be classified as mental defect. Op. cit., p. 223.

then, in the words of the Committee, mental inefficiency 'must indeed be one of the major social problems which a civilised community may be called upon to solve', and by dealing with it the community will at the same time go a long way to ensure the diminution of a number of other social ills.

If a social problem is to be tackled satisfactorily measures to mitigate its consequences must be combined with research into its causation, and preventive measures evolved to eliminate these causative factors. It is clear from the increased incidence of defect in the generation between the two investigations described above, that the legislative measures and voluntary provisions in this country have not been very successful in controlling the propagation of this condition. This is in part due to the fact that, in spite of much research into mental defect, there are still differences of opinion both as to the relative importance of different factors in its causation, and the measures which should be taken to reduce its incidence.

Mental defect is frequently divided into two types, primary amentia, which results from germ impairment or abnormality and which is passed on from generation to generation, and secondary amentia, which is due to disease or injury before or during birth or in early childhood.[1] In some subjects both psychotic inheritance and adverse environment appear to have contributed to the defect, and it may be that sometimes, at least, the defect although present is latent, and does not become manifest unless other abnormalities are present, or the ante-natal or post-natal environment is favourable to its development.[2] The Departmental Committee on Sterilisation was cautious in its pronouncements on causation,[3] but as the result of an enquiry into the mental condition of children of known defectives it concluded: 'It is impossible in the present state of our knowledge about the causation of mental defect to forecast with certainty whether the child of any given union will exhibit

[1] Some authorities prefer to divide cases of defect into 'subcultural' and 'pathological' groups, the former being made up of those who are found at the lower end of the normal intelligence scale, while the latter show marked pathological characteristics and cannot be regarded as normal variants, see L. S. Penrose, *Mental Defect*, 1933, pp. 91–3, and *The Biology of Mental Defect*, 1949, pp. 44–5.

[2] Dr. L. S. Penrose considered that out of 513 cases he had investigated the condition could be ascribed solely to morbid inheritance in 29 per cent and to environmental factors in 9 per cent, but in 62 per cent both hereditary and environmental factors were present and were very difficult to extricate from one another. *Mental Defect*, 1933, pp. 89–91. Dr. Tredgold considers that about 80 per cent of defectives are primary amentias, 20 per cent secondary. Tredgold, op. cit., p. 21.

[3] Report of the Departmental Committee on Sterilisation, Cmd. 4485, 1933, ch. ii, pp. 15 and 19, H.M.S.O., cf. Tredgold, op. cit., p. 33.

mental abnormalities. It can, however, be shown that, whether the cause is bad heredity or adverse environmental conditions, or both, children of parents, one or both of whom are mentally defective, are on the average below the normal, and our enquiry shows that nearly one-third of such children as survive are likely to be defective, and more than two-fifths to exhibit some form of mental abnormality.'[1]

Some eugenists consider that the only way of reducing the incidence of mental defect is by the sterilisation of defectives, or at any rate certain types of them; but this suggestion is far from being universally accepted. It is opposed on ethical and religious grounds, and some authorities have questioned its efficiency and practicability. Thus, after trying to estimate the amount by which mental deficiency in the succeeding generation would be reduced by the sterilisation of existing defectives, and examining the working of the sterilisation laws in those American states where they had been in existence for some years, the Wood Committee stated that while they were not prepared to deny that this measure might, with adequate safeguards, prove of value in a very limited number of cases selected from the more stable type of defective, they felt that 'there is not sufficient evidence at present to justify the general adoption of sterilization of defectives', and are convinced that 'even if it were adopted no great alleviation of the burden of mental deficiency would follow'.[2] A few years after the publication of this Committee's Report the Board of Control, with the approval of the Ministry of Health, set up a Departmental Committee under the chairmanship of Dr. L. G. Brock to consider the specific question of the sterilisation of the unfit. This Committee, after discussing the causation of mental defect and disorder, and endeavouring to assess the physical, psychological and social effects of sterilisation, recommended that it should be legalised in the case of mentally defective or disordered persons, persons suffering from or believed to be carriers of grave physical disabilities known to be transmissible, and persons likely to transmit mental disorder or defect; but that the operation should only be performed with the written authorisation of the Minister of Health on the recommendation of two medical practitioners, and, a very important proviso, with the consent of the patient if he were capable of giving it, if not with the full understanding and consent of his parent or guardian. Compulsory sterilisation was ruled out.

It is more than twenty years since the Brock Committee made these recommendations, but no attempt has been made to imple-

[1] Op. cit., p. 21. The enquiry is described in detail, pp. 60–74.

[2] Report of the Mental Deficiency Committee, Part III, *The Adult Defective*, p. 88.

ment them, nor does there seem to have been any revolutionary discovery or radical change in public opinion which would make the early introduction of sterilisation likely. This leaves such measures for the segregation and community care of defectives as have been sanctioned by law as the only safeguards against the propagation and control of mental defect and hence it is important that they should be both adequate in themselves and efficiently carried out. The Brock Committee concluded their Report, 'If there is one conviction which has stamped itself on our minds as beyond any possible doubt, it is the disastrous social consequences of ignoring defect'.[1]

Legislation for the protection and care of mentally defective persons is embodied in the Mental Deficiency Acts of 1913 and 1927, in the Education Act, 1944, and the National Health Service Act, 1946. Not all defectives come within its scope. Idiots and imbeciles of any age may be placed in institutions or under guardianship, provided that the application is accompanied by two medical certificates, one of which must be signed by a practitioner approved by the Local Health Authority or the Ministry of Health. Parents of feeble-minded persons under the age of twenty-one have similar powers, except that in these cases a certificate from a judicial authority is also required.[2] Otherwise defectives are only 'subject to be dealt with' under the Mental Deficiency Acts if they are neglected, abandoned, cruelly treated, without visible means of support, in need of care or training which cannot be provided at home, habitual drunkards, found guilty of a criminal offence or undergoing imprisonment or detention by order of the court.[3] All these conditions indicate that the person concerned is not being properly protected or cared for or cannot make a satisfactory adjustment to life, but the provisions described are open to criticism on the grounds that it is not until the damage has been done to the defective himself or to others that the law intervenes. There is, however, a valuable preventive measure which includes within the scope of the mental deficiency provisions children referred to the Local Health Authority by the Local Education Authority, either because they are 'incapable of receiving education at school' (that is even at a special school for educationally sub-normal children) or because, by reason of their disability of mind, they might require supervision after leaving school[4]. In fact the majority of cases of mental defect brought to the notice of the

[1] Op. cit., p. 56.
[2] Mental Deficiency Act, 1913, Section 3, as amended by the National Health Service Act, 1946.
[3] Mental Deficiency Act, 1913, Section 2.
[4] Education Act, 1944, Section 57.

Local Health Authorities are referred by the Local Education Authorities.[1]

The type of care needed by a mental defective depends on various factors such as the degree and nature of the defect, the temperamental stability of the defective and his home circumstances. Low-grade defectives and those who are unstable or defective in moral sense or who combine mental defect with some other form of abnormality or disease, usually require institutional care, but, given adequate supervision, higher-grade stable defectives can often remain happily and safely in the community and may even be able to support themselves.[2] The necessary care may be secured by placing the defective under 'statutory supervision' which involves regular visits from an officer of the Local Health Authority to see that all is well, or, if more rigid control is required, by arranging for his 'guardianship' by a responsible person. Local Health Authorities are responsible for ascertaining the defectives in their areas who are 'subject to be dealt with', and for providing appropriate supervision, or, if necessary, making arrangements for the guardianship, of those who remain in the community. They must also provide for the training and occupation of these defectives either by means of home teaching or by establishing occupation centres. These centres cater primarily for imbecile children excluded from school, and have already been described in Chapter XII, but older defectives may benefit from the training given if premises and staffing permit of their inclusion.[3] Some local authorities provide 'industrial centres' where adults are taught and practise simple occupational skills such as brush-making and rug-making, as well as their occupation centres for children.

The majority of defectives receiving residential care are looked after in institutions which are sometimes known as 'colonies', for

[1] In 1948, 6,442 defectives were ascertained to be 'subject to be dealt with'. Of those 4,394 had been reported by Local Education Authorities. Annual Report of the Ministry of Health, 1949, p. 283.

[2] A survey of the occupations and home conditions of mentally defective persons in an industrial area with a population of about half a million showed that in 1949 44 per cent were self-supporting, 20 per cent partially self-supporting, 9 per cent useful at home, 26 per cent were regarded as unemployable and 1 per cent were employable but out of work. A number of those in the partially self-supporting group were employed at an Industry Centre for adult males and females where they are paid a small wage. J. Squire Hoyley, 'Home Conditions and Employment of Mental Defectives', *Mental Health*, Vol. X, No. 1, Autumn 1950, p. 10.

[3] The duty of providing suitable training or occupation for defectives who are under supervision or guardianship is laid on the local authorities by the Mental Deficiency Act, 1913, Section 30, as amended by the Mental Deficiency Act, 1927, Section 7.

which the Regional Hospital Boards are now responsible. In a well-organised colony defectives are carefully classified and housed in separate villas, and those who are able are trained to undertake simple routine work in the laundry, farm or gardens. Recreational facilities including outdoor games, scouting and guiding are also available, and at its best the system 'is as near an approach as possible to village life, providing a large measure of freedom and amenity'.[1] A colony thus provides the ordered, sheltered environment in which those types and grades and defectives who are unable to stand up to the stresses and uncertainties of the world outside can live happily and contentedly, and find scope for such abilities as they possess.

The colony is, perhaps, least successful with the young high-grade defectives, sent there not for life, but for rehabilitation and stabilization, so that one day they can return to the general community more mature and settled. The institutional atmosphere, the lack of real incentives and training, the isolation of the institution from the rest of the community, and its routine adjusted to the needs of permanent low-grade patients, depress the higher-grade patient, and may make his subsequent adjustment to life more difficult. More might be done in the way of 'training schemes' and hostels for this type of case.[2]

Unfortunately, the shortages of staff, buildings and equipment which dog all forms of residential social and medical care are found in a marked degree in institutions for the care of the mentally defective. While in some institutions it is not possible to make use of all the accommodation available because of shortage of staff, others are overcrowded, but everywhere there are long waiting lists,[3] so that many defectives remain at home year after year, often in most unsuitable surroundings, deteriorating for lack of social training, and a source of grave anxiety to their relatives and those in contact with them. These shortages are of long standing, but appear to have received less public attention than comparable shortages in accommodation for persons with tuberculosis or other physical illnesses. Until action is taken to remedy them the proper care and control of defectives is impossible, and mental defect will remain a grave social menace.

In some respects the social problems resulting from mental disease are closely akin to those of mental defect, but there are important differences. In both the question of control, with the

[1] Report of the Feversham Committee on the Voluntary Mental Health Services, 1939, p. 151.

[2] H. C. Gunzburg, 'The Colony and the Young High-grade Mental Defective', *Mental Health*, Vol. IX, No. 4, Summer 1950, pp. 87–92.

[3] Report of the Ministry of Health, 1953. pp. 14–15.

related issue of the liberty of the subject, may arise, since the person concerned may be or become temporarily or permanently unable to manage his own affairs, but while this condition is, by definition, a criterion of mental defect, it only arises in the severer forms of mental disease. Moreover, while a defective can be trained to make the best of his limited abilities, there is, in general, no hope of a complete cure, and social care and control are required rather than medical treatment.[1] This may also be true of certain forms of mental disease, but as a result of advances in psychiatry, neurology and brain surgery, this form of illness is becoming gradually more amenable to treatment, particularly if it can be given in the early stages of the disorder, and in these cases social care is regarded not so much as an end in itself as a part of treatment.

Past and present legislation dealing with mental disease reflects the changes which have taken place in the community's attitude towards it.[2] For centuries a person suffering from mental disorder was regarded as 'a lunatic'—one possessed by a mysterious and evil power who must be constrained for his own sake and that of others. Restraint was harsh, for ignorance, superstition and fear characterised men's attitude towards mental sickness, and whether the patient was confined in a public hospital such as Bethlem Hospital, London, or shut away in a private asylum, he was liable to be confined in a dark and insanitary cell manacled, starved and ill-used. It was not until the end of the eighteenth century that things began to improve, with the first tentative attempts at the licencing and inspection of private asylums;[3] the provision of more accommodation for pauper patients, and, perhaps most significant of all, William Tukes's courageous and imaginative experiment at 'The Retreat', York, where the chains were struck off, and lunatics were treated as sick persons and not as dangerous beasts. In 1828 a further step forward was taken by the appointment of the Metropolitan Commissioners in Lunacy, and this was followed in 1845 by an important Act which established a permanent Board of Commissioners in Lunacy with general jurisdiction over the whole of England and Wales, and wide powers to investigate conditions

[1] For a discussion of the possibilities and limitations of medical treatment in connection with mental defect, see L. S. Penrose, *The Biology of Mental Defect*, pp. 225–8.

[2] A brief historical summary is given in the Report of the Ministry of Health, 1949, pp. 125–7.

[3] The first Act for this purpose was passed in 1774. It was largely ineffective, because the visiting bodies (five Fellows of the Royal College of Physicians in London and justices at quarter sessions in other parts of the country) had no real power.

in asylums, gaols, workhouses and licensed houses.[1] At the same time rules were made for the reception of both private and pauper patients. During the succeeding half-century these provisions were tested out and elaborated, and the gains won as the result of a century and a half of effort were consolidated in the Lunacy Act, 1890, which ensured the proper certification, care and control of persons of unsound mind, and the provision and inspection of asylums and licensed houses.

The Lunacy Act was an important one, and although now sixty years old, its provisions are still in force, and constitute the legal means of dealing with those cases where loss of volition makes certification and compulsory detention necessary. However, in the main it rested on a conception of mental disorder which was already beginning to be out of date when it was passed. As the twentieth century advanced and new psychological discoveries resulting in a new approach to the whole problem of mental illness were made, and new treatments were adopted, it was gradually realised that in some respects the provisions of the 1890 Act were hindering further advance, and it must be supplemented by new legislation. In particular, the elaborate legal safeguards against wrongful detention which it contained militated against early diagnosis and treatment, while the position was further complicated by the close association between lunacy and the Poor Law which the Act had confirmed.[2] Consequently, a Royal Commission was appointed to investigate the question and reported in 1926. Its recommendations were based on the principle that 'the treatment of mental disorder should approximate as nearly to the treatment of physical ailments as is consistent with the specific safeguards which are indispensable when the liberty of the subject is infringed,'[3] and this principle forms the basis of the Mental Treatment Act, 1930.

The difference in approach between this Act and its forerunners is clearly shown by the terms used. The words 'lunatic' and 'lunatic asylum' disappear and are replaced by 'person of unsound mind' and 'mental hospital', the last term emphasising the constructive and hopeful attitude to the problem of mental disease which the title of the Act proclaims. Its most important provisions are those which make it possible for two categories of patient to be treated in a mental hospital without certification. These are 'voluntary patients' and 'temporary patients'. The former enter

[1] A licensed house is a house licensed for the reception of persons of unsound mind, run by private persons for profit.

[2] In further discussion of these points the Report of the Feversham Committee, ch. v.

[3] Report of the Royal Commission on Lunacy and Mental Disorders, Cmd. 2700, 1926, p. 157. The discussion of policy in ch. ii is very interesting.

hospital at their own request, and may take their discharge at seventy-two hours' notice; in the second category are those who have lost volition and so cannot themselves apply for admission, but who are likely to make a speedy recovery. They may be admitted for treatment on the recommendation of two medical practitioners, and can be detained in hospital for not more than six months without certification. The provisions for the admission of voluntary patients are particularly important as they do much to facilitate the treatment of the neuroses, those milder forms of mental illness in which the patient is still able to co-operate in his own treatment.[1] The increasing use made of them is shown by the rise in the proportion of voluntary patients admitted to County and Borough Mental Hospitals from 13·2 per cent of all admissions in 1933, to 59·2 per cent in 1948,[2] and these proportions might have been even higher but for the shortage of accommodation in many hospitals, which has led to the refusal of voluntary patients because of the need of reserving beds for certified ones.

A provision of the Mental Treatment Act which has proved of great value for early and less severe cases is that which authorises the establishment of psychiatric out-patient clinics in connection with either mental or general hospitals, while the importance of after-care was recognised by the inclusion of a clause empowering local authorities 'to make provision for the after-care of any persons who have undergone treatment for mental illness, and to contribute to the funds of voluntary associations formed for that purpose'.[3]

The Mental Treatment Act marked the transition from emphasis of the care of the mentally ill to emphasis on their treatment, and provided new opportunities for doctors, administrators and other workers concerned with this problem. In their evaluation of the mental health services made nine years later the Feversham Committee expressed some disappointment that fuller use had not been made of these opportunities. In many areas clinics were inadequate;[4] there was a serious shortage of hospital accommodation, particularly for early and curable cases;[5] comparatively few authorities realised the importance of employing trained mental

[1] An experiment which anticipated the Mental Treatment Act was the Maudsley Hospital which started an out-patient clinic and made provision for voluntary and curable cases.

[2] Annual Report of the Ministry of Health, 1949, p. 131.

[3] These powers are now exercised under Section 28 of the National Health Service Act.

[4] 'A study of the evidence reveals a further disquieting feature in the present position; that a number of authorities are paying only lip-service to the provisions of the Mental Treatment Act', op. cit., par. 175, p. 61.

[5] Ibid., par. 243, p. 85 and par. 250, p. 89.

health social workers and in any case there were too few of them to meet the demands of those areas where their work was appreciated,[1] and above all there was a serious lack of co-operation both locally and centrally.[2] But, in spite of these deficiencies, progress was being made, public confidence in the mental hospitals as centres of treatment, both out-patient and in-patient, was growing as the years went by, and was further enhanced by advances in the understanding of mental illness and in methods of treatment.[3] The Second World War brought a number of psychiatric problems in its train. It is true that as far as civilians were concerned they were not precisely what the mental health experts had expected,[4] but they were real enough, particularly among evacuated children and in the services. Psychiatrists and psychiatric social workers played an important part in solving them, and thus increased further the prestige of mental health work among government departments, local authorities, and among the population generally. Moreover, the nature of much war-time illness emphasised the close relation between bodily and mental health, and, in general, by the end of the war the country had come to regard the mental health services as among the health provisions to which they were entitled. This attitude found its expression in the National Health Service Act.

The Act makes important changes in the administration of mental health services, changes which are designed to bring them into conformity with the general pattern of all the health services and to minimise the distinction between mental and physical illness. The first of these is an important transfer of central responsibility. Until the implementation of the Act the general supervision of both mental deficiency and mental treatment services had been vested in the Board of Control. This body was created by the Mental Deficiency Act, 1913, and took over the powers and duties of the Commissioners in Lunacy, as well as assuming the additional responsibilities created by this Act. Under the Mental Treatment Act it was reorganised, but continued to

[1] Ibid., pars. 278–80. pp. 98–9.

[2] Ibid., pars. 223–32, pp. 78–81 and 88 and Part VI, pp. 227 ff.

[3] A short account of the progress of mental hospitals from early times until the Second World War is given in an article by Dr. W. Gordon Masefield, in *Mental Health*, Vol. X, No. 2, pp. 31–5, 'The Progress of Mental Hospitals'.

[4] They foretold a mass outbreak of hysterical neurosis among the civilian population as a result of bombing. In fact this did not occur and the majority of people in the target areas adjusted themselves well. 'The most prevalent and most marked symptom of psychological disturbance among the civilian population during the war was not panic or hysteria, but bed-wetting, which was prevalent among the evacuees', and observation showed that it was primarily caused by separation from the family. R. M. Titmuss, *Problems of Social Policy*, ch. xvii, 'Argument of Strain', p. 349.

exercise wide administrative and quasi-judicial powers. The National Health Service Act transferred its administrative functions including the licensing of houses, registration of hospitals and approval of nursing homes for mentally sick, the certification of institutions for mental defectives, and the superintendence of the administration by local health authorities of their powers and duties under the Mental Deficiency Acts, 1913–38, to the Ministry of Health.[1] The Board still retains important responsibilities in matters affecting the liberty of the subject. These include the inspection of all institutions for mental defectives and persons of unsound mind, whether these institutions are maintained as part of the National Health Service or no, and the visiting of voluntary patients in general hospitals, homes, or in the care of private individuals.[2] It manages Broadmoor and certain institutions for dangerous defectives. It would have been an advantage if, while these changes were taking place, the Lunacy Code could have been revised. A Royal Commission has been appointed under the chairmanship of Lord Percy to inquire into the law governing certification, detention, care, licence, discharge and supervision of persons suffering from mental illness or defect, and to consider the extent it is now, or should be made possible for them to be treated as voluntary patients. Its findings should be of interest and importance.

In local administration the pattern of the mental health services now conforms closely to that of other health services. Thus all hospitals and institutions with out-patient clinics attached to them, together with certain clinics not connected with hospitals at which specialist advice is given, have been transferred to the Minister of Health and, with the exception of those institutions managed by the Board of Control, are now administered by the Regional Hospital Boards. Local Health Authorities retain the responsibility for the community care of defectives and persons of unsound mind, including the initial care and removal to hospital of persons who are dealt with under the Lunacy and Mental Treatment Acts; the ascertainment and where necessary removal to institutions of mental defectives, and their supervision, guardianship, training and occupation if they remain in the community; and the preventive care and after-care of all types of patient in so far as this is not otherwise provided for.[4] There is thus a division of responsibility between the Regional Hospital Boards and the Local

[1] National Health Service Act, 1946, Section 49.

[2] National Health Service Act, 1946. *Provisions relating to the Mental Health Services*, H.M.S.O., 1948, p. 20.

[3] The Commission started work early in 1954.

[4] Ministry of Health, *Provisions relating to the Mental Health Services*, 1948, par. 40, p. 11.

Health Authorities similar to that noticed in connection with the maternity and the tuberculosis services, but the Ministry has sought to obviate this by stressing the possibilities of 'joint-user' appointments,[1] and this recommendation has been carried out in some areas with good effect.

One of the characteristic features of the local administration of the mental health services before the passing of the National Health Service Act was the maintenance of separate mental deficiency and lunacy and mental treatment services with different committees, but the local Health Committee, working probably through a Mental Health Service Sub-committee, has now been made responsible for the control of what is intended to be a unified mental health service.

In discussing the developments which have taken place in the mental health services to date we have concentrated in the main on legislative changes and the developments in the statutory services. To leave the matter there would, however, be a grave injustice to various voluntary organisations which have been responsible for so much of the advance which has taken place. They have continuously pressed for reform, and have themselves undertaken pioneer and experimental work in the community care of defectives, including the provision of occupation centres, and the after-care of the mentally sick, and, before the war, the value of their work was recognised by local authorities in many areas who delegated their mental health responsibilities to them. In 1942 the major voluntary organisations concerned with mental health[2] combined under the pressure of war to form the Provisional National Council for Mental Health, and this has now become the National Association for Mental Health. This active body undertakes educational work, research, experimental services, and services for special groups, such as the agricultural hostels it has started for high-grade defectives, the holiday homes it maintains for parties from occupation centres, mental deficiency institutions and mental hospitals, and the home provided for senile old people not ill enough to require mental hospital care. The association thus seeks both to supplement and to stimulate the statutory mental health services with the object of bringing about a state of affairs in which the mental health of all members of the community will be as carefully safeguarded as their physical health.

The mental health services to-day are thus both complex and

[1] Ministry of Health Circular 100/47, *Mental Health Services to be provided by the Local Health Authorities*, par. 6 (c), p. 3.

[2] The Central Association for Mental Welfare (which concerned itself mainly with the welfare of defectives), the Child Guidance Council and the National Council for Mental Hygiene.

comprehensive. They are a measure of the advances that have taken place, and, if properly used, should form the starting-point for further progress. Thus, in 1946, when the incorporation of the mental health service in the general health services was under consideration, the Board of Control wrote, 'The Board of Control welcome the integration of the Mental Health Service with the National Health Service. They have long held the view that further progress in the treatment of mental illness would depend largely upon the closer association of psychiatry with general medicine, and the breaking down of that isolation by which the treatment of mental illness has so often been handicapped. We believe that in the development of the integrated service there are invaluable opportunities for expanding the scope and increasing the efficiency of the mental health service.'[1]

If the opportunities for advance are great the obstacles to it are formidable. One of the most serious of these is the shortage of institutional accommodation of all kinds, which is due in part to the cessation of building during the war, and the difficulties of getting it going again since, which have accentuated an already existing deficiency, and in part to the shortage of nurses. The overcrowding in mental hospitals is so serious that the admission of voluntary patients is restricted, a state of affairs which is 'detrimental to the whole system of voluntary treatment' and inflicts grave hardship.[2] The shortage of in-patient accommodation has increased the amount of work which must be carried on by the psychiatric out-patient clinics, and the scope and importance of community care. Here, in many cases, challenge has led to response, and some interesting developments are taking place in these branches of the service. Thus some psychiatrists have been trying to overcome the pressure of numbers by experiments in group therapy, a method of treatment which has been found to have advantages of its own; day hospitals, mostly very small units, have been started in a few areas, while therapeutic social clubs for the mentally sick are another experiment.[3] Developments of this nature in out-patient and community care are less spectacular than the drastic methods of treatment such as shock therapy, narcosis and pre-frontal leucotomy which have recently captured the public imagination, but they are important. If the patient is to recover he must make an adjustment to his social environment, and while he may need to be taken away from the community for a

[1] The Thirty-third Annual Report of the Board of Control for the year 1946, Part I, p. 5.

[2] Report of the Ministry of Health for the year ended 31st December 1947, p. 217.

[3] Report of the Ministry of Health, 1953. Part I, p. 16. Part II, p. 124.

time for intensive treatment or care, this may not be necessary if he can get adequate psychiatric and social help sufficiently early, and if it is, he is likely to need such help on his return. Every aspect of his treatment is important, and throughout he must be regarded as a person in or from a particular social setting, which may need to be modified, but which cannot be ignored.

In this process of adjustment between patient and community—this 'restoration of impaired relationship'—the psychiatric social worker[1] plays a particularly important part. Much of her work is done in hospitals and clinics where it is complementary to that of the psychiatrist. Her function is to some extent that of an interpreter. At the start of the case she interprets the particular psychological approach which is to be made to the problem to the patient and his relatives, and the social problems leading up to and involved in the situation and the likelihood of their repercussions on the treatment to the psychiatrist. During treatment she helps to remove or minimise some of the practical difficulties in the patient's environment, or helps him to adjust himself to his circumstances—a task which usually involves obtaining the co-operation of his relatives, and when the time comes for discharge she may have a part to play in his after-care.[2] Probably the majority of psychiatric social workers working with adults are attached to hospitals or clinics, but others hold key positions in the community care services being developed by local authorities where their work is equally valuable. The shortage of psychiatric social workers is acute, but where their services are available the importance of the special contribution which they have to make to the rehabilitation of the mentally sick is becoming increasingly recognised.[3]

In this study of the mental health services we have seen how the emphasis has gradually shifted from custody to treatment, which now holds the central place. It is, however, becoming increasingly evident that this position cannot be regarded as final.

[1] 'A psychiatric social worker is a social worker who, in addition to her general social work training has received a special training designed to fit her for work with children or adults suffering from mental illness or problems of personality'—definition taken from Noel K. Hunnybun's paper on Psychiatric Social Work in Cherry Morris (ed.), *Social Case Work in Great Britain*, pp. 100–26.

[2] Compare this summary with a paper on 'The Role of the Psychiatric Social Worker', by Miss K. M. Lewis, *British Journal of Psychiatric Social Work*, October 1950, pp. 15–22. The same journal has published several other interesting and provocative articles on this topic. Compare the description of the role of the psychiatric social worker given here with that of the hospital almoner given in Chapter VII, above.

[3] See Ministry of Health, Report of the Committee on Social Workers in the Mental Health Services, Cmd. 8260, 1951.

We must not only treat those who are sick, but endeavour to safeguard and improve the mental as well as the physical health of the people. This objective opens up a whole new field of preventive and educational work. It is already being explored to some extent in the work which some psychiatric social workers are doing in maternity and child welfare centres[1] and the discussions initiated by the Family Discussion Bureaux,[2] but much more extensive experimentation linked with fundamental research into the psychosocial problems of modern life is needed. The roots of mental ill-health both in the individual and in society go deep and it may well be that only a reordering of men's relationships with each other, and with the natural and spiritual worlds to which they belong, can bring about the wholeness which they crave. Psychologists, psychiatrists, psychiatric social workers and all concerned with mental health can enable us to see these psychological and social problems more clearly, and so help us to solve them.

[1] For a description of this see Betty Joseph, 'A Psychiatric Social Worker in a Maternity and Child Welfare Clinic', *British Journal of Psychiatric Social Work*, August 1948, pp. 30–40.

[2] See Chapter VIII, above.

PART FIVE

COMMUNITY SERVICE

What life have you if you have not life together?
There is no life that is not in community,
And no community not lived in praise of God.

When the Stranger says: 'What is the meaning of this city?
Do you huddle close together because you love each other?'
What will you answer? 'We all dwell together
To make money from each other', or 'This is a community'?—T. S. ELIOT.

CHAPTER XX

SETTLEMENTS AND COMMUNITY CENTRES

THE Temporary Social Committee of the United Nations has laid it down that the standard to be attained in a social welfare programme is 'the well-being of the community so as to enable each to develop his personality . . . and at the same time to enjoy, from youth to old age, as full a life as may be possible'. This statement epitomises a conception of social service which, although it has always been present in some degree, is becoming increasingly emphasised now that the worst evils of poverty and preventible ill-health are being overcome. It rests on the assumption that the universal provision of services to maintain minimum standards of health and decency, although important, is insufficient in itself. Even if these universal basic provisions are accompanied by patient individual care designed to help those with personal handicaps to reach the level of the majority there is still more to be done, for a society which truly seeks the welfare of its members is not only concerned that they shall live, but that they shall have opportunities for more abundant life.

One of the pioneers in the provision of such opportunities for those who conspicuously lacked them was Canon Barnett, who became vicar of St. Jude's, Whitechapel, in 1873, and his work had far-reaching consequences. At that time this East End parish consisted almost entirely of a network of insanitary courts and alleys in which lived a degraded population of casual labourers, hawkers, beggars and thieves, and when he came to know his parishioners, Canon Barnett became increasingly sensitive not only to their material poverty and to the physical squalor of their surroundings, but also to their spiritual, intellectual and cultural poverty and the drab monotony of their lives. Hence, he not only sought to overcome the worst of the housing and kindred evils by every kind of influence he could muster; he not only sought to restore people to some measure of self-respect and independence by reorganising the relief giving connected with his church on C.O.S. lines; but, secure in a belief in 'the equal capacity of all to enjoy the best', he provided opportunities for the people of the neighbourhood to hear

good music, to have access to books and pictures[1] and make good some of the educational opportunities they had missed.

As Canon Barnett pursued his self-appointed task of restoring their heritage to the culturally disinherited inhabitants of Whitechapel, he came to believe that the 'poverty of life', as he described it, of his parishioners could be relieved by continued contact, leading on to friendship, between these people and people of culture and education. Hence he conceived the idea of 'bringing the life of the university to bear on the life of the poor' by founding 'settlements' in working-class areas. In a settlement men of university standing and education would live as members of a community; from here they would go out and learn to know the people of the neighbourhood; help them in any way for which they were suited by character and inclination, and gain from them a fuller understanding of social conditions. In this way the immense gap between the privileged few and the poverty-stricken many would be bridged, and through friendship they would realise their common citizenship.[2]

The first settlement founded was Toynbee Hall in Canon Barnett's own parish of Whitechapel. He himself was largely instrumental in getting it started and became the first Warden. Soon numerous others were founded in various parts of London, chiefly by men and women associated with the universities and public schools, and the idea spread to the provinces, to America, and to all parts of the world.

Individual settlements have developed along different lines, according to the needs and circumstances of the neighbourhoods they set out to serve, and the predilections of their founders and workers. Play centres for young children and clubs for people of all ages from older boys and girls to men and women over sixty are usual, and educational classes, now often held in conjunction with the Local Education Authority or the Workers' Educational Association, are provided where there is a demand. Settlement premises are also frequently centres of individual welfare work, and house such organisations as the local Poor Man's Lawyer, Citizens' Advice Bureau or branch office of the Invalid Children's Aid Association.

From the first certain settlements have regarded the study of social conditions as an important part of their task, and some of the social investigations undertaken in connection with settlements

[1] This in spite of the fact that he was himself both colour blind and tone deaf!

[2] The idea was first set out in a paper read by Canon Barnett at St. John's College, Oxford, 17th November 1883. This paper is printed as an appendix in J. A. R. Pimlott, *Toynbee Hall*, 1938. See also Henrietta Barnett, *Canon Barnett, his Life, Work and Friends.*

have been of far-reaching importance. Thus, 'It was from researches conducted as a Toynbee Hall settler that William Beveridge hammered out his thesis that unemployment is primarily a problem of industry rather than a problem of personal character or particular misfortune. It was from personal encounters between the sweated workers of East London and a group of Oxford settlers that the sweated industries campaign generated the impetus which led to the tentative reappearance of statutory wage regulation in 1909, and the Manchester Settlement produced the man (J. J. Mallon) who carried that campaign to fruition. There is indeed scarcely any field of social legislation or any statutory instrument of social service which does not owe something of its inception or direction to the recorded observations or voluntary experiments of settlers who, year by year, followed the call of Samuel Barnett to those mean streets where their fellow-citizens led anxious meagre lives.'[1]

A valuable tradition which many settlements have built up over the years is that they have established a continuing link with certain families of the neighbourhood. Provisions are made to meet the needs of all age groups and both sexes, and so the different members of the family all come to be known, and while each follows his particular interest, the life and atmosphere of the settlement is shared and felt by all. Moreover the transition from one age group to another is easy, and the individual can progress from childhood to maturity or even old age without severing his link with the settlement, while his children follow in his footsteps and he takes an interest in their pursuits and progress. 'It is not that the family is treated as a unit, which might be undesirable, but the continuity of interest in each individual establishes a family connection between him and the settlement.'[2] The settlement thus becomes the centre round which much of the family's social life revolves, an example of the way in which a community service can help keep a family united.

While much of the work carried on at or in connection with the settlements is as necessary and valuable now as when they were first started, in some respects the movement, like the C.O.S., was a product of its time, a child of the age in which it was born. At that time the social cleavage between the classes was marked; there had hardly been time for the effects of universal education to make themselves felt; and until the last decade of the century trade

[1] Mary Stocks, *Fifty Years in Every Street*, the story of the Manchester University Settlement, 1945, p. 3.

[2] P. J. O. Self, 'Voluntary Organisations in Bethnal Green', ch. xiii in A. Bourdillon, *Voluntary Social Services in the Modern State*, 1945, p. 248. Compare this point of view with that of those responsible for the policy of the Peckham Health Centre. See Innes H. Pearse and L. H. Crocker, *The Peckham Experiment*.

unions, Co-operative societies and other workers' organisations, with their demands for corporate self-reliance, scarcely touched the unskilled labourer. Hence it seemed both right and natural to both givers and receivers that schemes for relieving distress and raising standards in a poor neighbourhood should be promoted, financed, and largely carried out, by people of a different background coming into the area from outside. To-day we live in a society which is both better educated and more self-consciously egalitarian, and settlements throughout the country are facing the task of adapting themselves to changed conditions without losing much that is valuable in their tradition. To do this they have had to become both more democratic and more truly part of the life of the local community. 'Their work is no longer so much helping those who cannot help themselves as providing a framework within which people can use their own initiative.'[1] This reorientation is not always an easy task. Some settlements are saddled with constitutions which reflect the conditions and spirit of the age in which they were founded, and there may also be some difficulty in accustoming the people of the neighbourhood to a change from 'dispensation' to 'co-operation'. They must learn to shoulder the burden of general financial responsibility, and instead of having things done for them learn to do them for themselves and for others, and 'this volte-face is bewildering and will take time to assimilate'.[2] If these difficulties can be overcome, and the transition accomplished, settlements can continue to do much valuable social and educational work in their neighbourhoods and the newer community centre movement will be enriched by the tradition they will be able to carry over to it.

Settlements came into being as the result of the concern of a sensitive and educated man about his neighbours' lack of opportunities for sharing in the rich cultural heritage of the society of which they were nominal, but to a great extent disinherited, members. Although material conditions were much better, this same cultural poverty characterised the housing estates built between the wars, and to it was added the social isolation of many of the families who came there to live.[3] It was on these housing estates and in response to the needs of the inhabitants that community associations came into being and community centres were built.

The origins of the first community associations and centres were varied. Some arose spontaneously, while others were inspired by

[1] P. J. O. Self, op. cit., p. 248.

[2] Harvey Sheppard, Head of Cambridge House Settlement, 'Settling in a New World', *Social Service*, Vol. XVII, No. 4, March–May 1949, p. 179.

[3] See above, Chapter VI.

interest and leadership from without, as when an old-established settlement in a slum area started a branch or sent some of its workers to live on an estate to which a number of its families had moved.[1] Where and when associations arose as a result of the efforts of the tenants themselves, it is doubtful if, in the early days at any rate, their aims were as abstract and self-conscious as they have since become. These people formed Gardens Guilds because it was cheaper to purchase seeds and fertilisers collectively in bulk rather than individually in small quantities; Tenants' Associations because they wanted to protest about the inadequacy of the local bus service, the iniquity of the electricity charges or the inefficiency of the grates which had been installed; or Social Clubs because they wanted to hold whist drives and provide treats for their children; that is they came together because there were certain things they wanted done which could only be done in association. In pursuit of these common interests they learnt to know each other, and slowly, and often only as the result of outside influences or the outstanding leadership of one of their own number, they began to realise that such activities could interlock and fit in to the wider conception of a community association. Moreover, some associations, although they might pay lip-service to the high-sounding objectives of the community associations movement, never really made them their own and remained little more than social clubs.

The associations started as the result of inspiration from without, for example, through the influence of a settlement, were more deliberately planned, and from the start often included a variety of activities for different age groups. These ventures made valuable contributions to the development of social life on the estates, particularly perhaps on slum clearance estates where conditions were most difficult and internal leadership lacking. There have been instances, however, where, in spite of the efforts made to train local leaders, the work has flagged and died when the support from outside was withdrawn. It seemed as though the people could accept what was offered, but could not make it their own.

The history of the community associations movement has thus been a chequered one, with its disappointments and failures as well as its successes, but in many areas considerable progress has been made and strong associations maintained over a number of years. Moreover, the movement has spread, not only to housing estates

[1] For early histories of community centres and associations, started between the wars, see Terence Young, *Becontree and Dagenham*, 1944; Ruth Durant, *Watling, a Survey of Social Life on a New Housing Estate*, 1939; Mary Stocks, *Fifty Years in Every Street*, 1945; M. P. Hall, *Community Centres and Associations in Manchester*, 1946.

in all parts of the country, but to other types of area as well. This progress has been furthered by the encouragement and help given by the National Council of Social Service. In 1929 the Council formed a New Estates Community Committee and obtained a grant from the Carnegie U.K. Trust for the development of social work on new housing estates. Gradually the scope of the Committee widened to include the encouragement of associations and the provision of centres in areas other than housing estates. At the same time representation of the associations themselves on the central committee was encouraged, and ultimately an autonomous body, the National Federation of Community Associations, emerged. To-day this forms a link between centres and associations throughout the country.

Whatever the origins or activities of a community association its first need is for suitable premises, and in its early years much of the energy of an association may be directed to finding, building or adapting premises or to raising money for this purpose. Working for a tangible objective which is obviously beneficial to all members may have, and in many cases has had, a stimulating effect on the association concerned, and has helped to bind the members more closely together. Moreover, when the building is obtained and ready for use the members can really feel that it is their possession and their pride. Hence it is generally inadvisable, even if it be financially feasible, for a local education or housing authority or a private benefactor to rob the people of the neighbourhood of this opportunity for initiative and common action by building premises without expecting any contribution or effort on their part, or consulting them about its plans. Where this has been done the results have not always been good. On the other hand years of delay and frustration may stifle enthusiasm and result in apathy.

Statutory powers with regard to the building or adaptation of premises for community centres are contained in the Education Act, 1944;[1] the Physical Training and Recreation Act, 1937[2] and the Housing Act, 1936,[3] Local Authorities thus have powers under a number of different acts to provide or assist in the provision of community centres. In 1949, however, the Ministry of Education issued a circular limiting work on community centres to that of maintenance; for some years little could be achieved in the way of new building projects and the work of many centres was restricted and made more difficult. The position is easier now, as in December 1954 a new circular (Ministry of Education Circular No. 283) was issued. It states that the Ministry proposes to relax existing restrictions on grants in connection with the

[1] Section 41 b. [2] Section 4. [3] Section 80.

capital cost of village halls, community centres and youth clubs. Building programmes will again become possible and it is hoped that good progress will be made by both voluntary organisations and local authorities, since they have a wide body of knowledge and experience on which to draw.

When once a community association has become established, and acquired or hired premises of some kind on which to base its activities, the real test of its vitality and the contribution it has to make to the life of the neighbourhood begins. According to the Ministry of Education community centres exist 'so that neighbours can come together on an equal footing to enjoy social, recreative and educational activities either as members of groups following particular hobbies and pursuits or on the basis of their common needs and interests as human beings living in the same locality'.[1] Their purpose is thus educational in its broadest sense, but the centre is also intended as a focal and growing point of community life. The assumption here is that individuals and families living in a locality will, by doing things together which they find to be worth while, develop a common loyalty to the centre and neighbourhood which will do much to create that sense of belonging together which transforms a geographical expression into a local community.[2] In pursuit of this objective the association will not only welcome individual members who will join in its own activities and help to create its own group life, but it will also encourage other groups in the neighbourhood to affiliate to it, and, if premises permit, hold meetings at its centre. In this way the centre will become 'a power house of community effort'.[3]

Such high ideals and far-reaching plans were characteristic of the community centre movement during the period of transition from war to peace. They were closely linked with those of neighbourhood planning, since the community centre was designed to be the focus of the neighbourhood unit. As we have already seen[4] neighbourhood planning has itself been subject to a considerable amount of criticism of recent years, and the community centre movement has not escaped it.

The main criticism which has been made is that too much is expected in the way of unification from one type of social relation-

[1] Ministry of Education, *Community Centres*, 1945, p. 6.

[2] Cf. 'Neighbourhood does not, of itself, necessarily constitute a social bond; but if by grouping its leisure activities round a recreative and educational centre a neighbourhood can develop into a socially conscious community, learning through managing the affairs of a centre to participate intelligently in the work of local and national government, then education for democracy will have made a real advance', ibid., p. 4.

[3] National Council of Social Service, *The Size and Social Structure of a Town*, p. 17.

[4] Chapter VI, above.

ship, the leisure-time interest group in a local setting. As the writer of the P.E.P. pamphlet *Can Communities be Planned?* sees it the danger is twofold. 'The first [danger] is to forget that local communities are not the only social relationships open to people in a modern society [the most important alternative bond of association is probably that of common employment]. The second is to exaggerate the importance in a local community of organised activities', for while the provision of facilities which encourage communal activities can help to foster community life it cannot by itself create it. The influences which combine to create communities are more subtle, more far-reaching, slower and more secret in their working. At the same time, if exaggerated and diffuse claims be modified, and the community centre accepts the position that it is one of the many and various influences which combine to enrich the life of the neighbourhood, it can find its own special place and make its own special contribution.

The particular contribution a community centre has to make will vary from neighbourhood to neighbourhood according to social needs, and provision or lack of provision to meet them. In some areas the emphasis of the centre may be on providing facilities for common enjoyment of a more creative and sociable kind than the rather passive and individualistic pleasures of commercial entertainment, and this may lead some groups on to 'learning based on joy'.[1] In other neighbourhoods the most important contribution the association can make may be to give hospitality on the centre premises to struggling organisations frustrated for the lack of a place wherein to meet. Some centres may endeavour to cater for families rather than individuals, taking their cue from the Peckham Health Centre, while others may regard themselves primarily as adult organisations and leave the provision of activities for children and young people to other bodies. Yet another centre may have a youth wing, but one 'insulated' from the remainder of the centre.[2]

Thus the vitality of the community centre movement may most clearly manifest itself in the variety of ways in which it adapts itself to meet differing circumstances, the needs of differing neighbourhoods. This has been true of the settlement movement so that, for example, the educational settlements started in the Welsh mining valleys during the years of unemployment have developed along completely different lines from the early settlements in East London. In both the settlement and community centre move-

[1] The phrase is taken from David Hardman, 'New Pathways in Adult Education', *Social Service*, Vol. XXIII, No. 1, June–August 1949, p. 17.

[2] This is the arrangement favoured by the Ministry of Education in its pamphlet on Community Centres, op. cit., p. 13.

ments the distinguishing feature is, or should be, sensitiveness to the needs and wishes of the people of the neighbourhood in which the organisation is functioning. In these days of specialisation this is a particularly valuable contribution. At the present time many organisations and services are structured in such a way that particular interests and ideals of the organisation come first, the general interests of the locality second. A branch of such an organisation, which may for example be a political party or trade union or ex-serviceman's association, may serve those people who share particular needs or interests in an area, but its principal loyalties and activities go far beyond and outside this area, and may be dependent on or largely directed by a national committee which meets at the other end of the country. On the other hand a community centre or association may cater for the particular needs and interests of special groups, but it is concerned with them not only as ends in themselves, but as elements enriching the life of the neighbourhood. The basis of such an association and centre is thus geographical rather than functional, and it is complementary to the organisations with a more definite purpose. If organisations of both types are found in an area its inhabitants will have opportunities of developing a rich and varied social life. Their very existence is indeed a sign of such abundant life. We have already suggested that such organisations are likely to be insufficient in themselves to create that sense of belonging which is the basis of community, but at least they help to break down the social isolation which is so marked a feature of the life of many people, and make a real contribution to their happiness.

CHAPTER XXI

CO-OPERATION IN SOCIAL SERVICE

If this book has done nothing else it may perhaps have given the reader some idea of the range and variety of the social services. They all minister in some way to the personal well-being of the individual member of the community, but they differ in scope, purpose, approach and method of administration. Moreover, in the main their growth has been haphazard, since they came into being one by one as the community, or certain members of it, became aware of personal needs to be met, or social evils to be overcome. This process has given rise to an astonishing number and variety of voluntary and statutory social service organisations, and there is a tendency for each to deal with its own particular problems in its own way, with little reference to what the others are doing. Consultations between workers about individual cases, or specific problems, occur quite frequently, and, in general, good personal relationships exist between social workers in a particular area, but there is surprisingly little joint discussion on basic principles of social work and administration, or on major issues of social policy. There is, in fact, some justification for the criticism that social service is piecemeal and uncoordinated, and that, in spite of the lip service given to certain rather vague principles, it is lacking in any real sense of common purpose.

Both statutory and voluntary social services have been attacked on the grounds that their general incoherence and failure to work to any recognisable plan has meant overlapping, wasted effort, gaps and anomalies, resulting in frustration and misery to the people whom the services are trying to help. The undesirability of such a situation has, of course, long been recognised by those concerned with social policy, and, looked at from one point of view, the great series of measures of social reconstruction passed during the last years of the war and the period immediately following may be regarded as an attempt to bring order out of chaos, and to substitute planned development for haphazard growth. The call in the Beveridge Plan for a concerted attack on the Five Giants of Want, Squalor, Disease, Ignorance and Idleness[1] provided an

[1] Sir William Beveridge, *Social Insurance and Allied Services*, 1942, par. 8, p. 6.

objective which fired the imagination; such investigations as that of the Curtis Committee revealed the evils that arise when co-ordination is lacking; and war-time experience had conditioned the people to national planning on matters affecting their daily lives. Hence the years between 1944 and 1948 witnessed the creation of a unified system of national insurance, a comprehensive national health service, a national assistance service, and a co-ordinated service for the care of deprived children. All is not yet perfect, and some of the new schemes themselves have gaps and anomalies,[1] but if we compare our present basic statutory services with the corresponding provisions in 1939 it is clear that great steps have been taken in the direction of clarification and of unification.[2]

This is all to the good, but such co-ordinating policy may become dangerous if carried too far. Plasticity and spontaneity must remain, as the social services have continually to adapt themselves to men's changing needs and ideas, and administrative efficiency can be purchased at too high a price if it results in rigidity and uniformity. Real co-operation, while it may be hindered or assisted by the legislative framework, is free rather than imposed. It is an expression of breadth of vision and understanding of the totality of human needs on the part of workers and administrators. For this reason we cannot expect, nor should we desire, to achieve over the whole wide field of social service the unification that has come about in the social insurance and allied services as a result of the implementation of the Beveridge Plan. Instead, we should examine some of the ways in which co-operation has developed freely in the past, and consider the means by which such free co-operation can be furthered.

A long-established method of co-operation in case work is by means of Registers of Assistance and Care, which, started many years ago with the encouragement of the Charity Organisation Society and kindred organisations in London[3] and some of the larger towns, had as their object the avoidance of overlapping in the giving of relief. Agencies making use of such a register supply the names, addresses and relief given of cases assisted by them, and apply to the Registrar for information about the assistance given

[1] See, for example, the criticisms made of the National Health Service in Chapter V, and the unhappy position of the infirm and aged described in Chapter XVII.

[2] This is particularly true of the social insurances described in Chapter III, but the changes brought about in the child care services since the passing of the Children Act are also noticeable, while the nationalisation of the hospitals provides another example.

[3] The London Register has been given up owing to administrative difficulties.

by other agencies to the families seeking their help. Central Registers of this kind have helped to check wholesale cadging, and serve to let the different societies concerned with a particular case know which other registering agencies are in touch with it, but on the whole their value has not yet been fully realised or their potential usefulness developed. If they are to be made the basis of constructive co-operation, then, instead of being regarded simply as a method of preventing overlapping in the giving of material relief, they must be thought of as a way of facilitating co-operation at a case-work level. This means that an agency using a Register must register all cases advised and helped, and not merely those given material assistance. Further, a wider use will have to be made of the Registers. At present some important agencies register grants, but do not consult the Register before making decisions, others consult it, but refuse to record their own cases. Others do not use it at all. If a Register is to be really effective, it must be used freely by all the agencies in its area undertaking any form of case or relief work whether statutory or voluntary.

The free use of a Mutual Register raises an important issue, namely that of the responsibility of an agency to respect the confidence of its clients. Many statutory and voluntary bodies refuse to register, or they simply consult the Register without recording their own cases, because they regard the full use of a register open to organisations of all kinds as a breach of confidence. One suggestion that has been made to lessen this difficulty is that, in addition to the general registers described, a more selective register, limited to authorities and agencies accustomed to dealing with problems of a highly confidential character on a professional basis, might be set up.[1]

This proposal draws attention to two related issues underlying this question of confidence, namely that of the professional status of the social worker, and that of the absence of a formalised code of ethics covering the practice of social work. Where a profession is well established, close knit, and has, and is known to have, a strict code of professional ethics, then the client can have confidence in the profession as a whole, and not only in the individual worker or agency. This is true of medicine, for example, but is not yet true of social work. Hence, consultation between workers, which might be invaluable is hindered. The question is exercising the minds of social workers a good deal, as the inadequacy of a sectional approach to common problems is increasingly realised. It was discussed at some length in one of the Commissions at the 1950 British National Conference on Social Work, and the Com-

[1] Report of the Liverpool Working Party on Social Adjustment to the Harrogate Conference, 1950.

mission recommended that a National Committee of Social Workers be set up to draw up an ethical code governing 'the very delicate question of relationship with the client, and the form and type of disclosures as between different social workers, including the legal questions of admissibility of evidence'.[1] Such a code, if recognised and accepted, would enable social workers to have an agreed procedure for consultation, as is the case in the medical profession.

If the present obstacles to more complete confidence could be overcome it would be possible to make fuller use of two other means of co-operation between the differing social work agencies. One of these is the case conference, which has already been tried in some areas, and has been found to be particularly valuable in dealing with problem families, and in small and medium-sized towns and rural areas where there is no general case work organisation.

Official recognition of the value of a co-ordinated approach which would include the use of case conferences is contained in the joint circular of the Home Office, Ministry of Education and Ministry of Health, *Children Neglected or Ill-treated in their Own Homes*.[2] As we have already seen, this circular suggests that an officer be designated by the local authority for the purpose of securing co-operation among all organisations, statutory or voluntary, which are concerned with the welfare of children in their own homes, and that he should arrange for regular meetings of these organisations at which significant cases of child neglect could be discussed, and agreement reached as to how the local services could be applied to meet the needs of the family as a whole. Such conferences might well be the beginning of real co-operative action among statutory and voluntary bodies undertaking any form of family welfare work.

A further means of co-operation which has sometimes been advocated is that of the use by a number of different organisations of a general social worker as a welfare visitor, whose reports would be accepted by all. This is more difficult to envisage, however. Two objections can be made to this proposal, firstly, the difficulty of confidence already discussed, and secondly, the widespread belief that only a particular agency's own visitor, with her specialised knowledge and experience, can elicit precisely the information that agency requires, and give the appropriate advice and help. These are very real difficulties, and a great deal of care-

[1] British National Conference on Social Work, *Social Patterns*, 1950, p. 62.

[2] Circular 157/50 Home Office; 78/50 Ministry of Health, 225/50 Ministry of Education, 31st July 1950. This circular is also described in Chapter XIII, above.

ful thought, accompanied perhaps by small-scale experiments, will be needed before they can be overcome. Meanwhile, however, the growing complexity and specialisation among the case-work and related services, including the welfare services of the local authorities, makes the question of better co-operation an urgent one.

Furtherance of co-operation between the agencies undertaking some form of social case work is only part of the wider problem of securing the better co-ordination of all social work organisations. This is the main function of the National Council of Social Service. Founded in 1919, the National Council seeks to develop co-operation among voluntary agencies, and between them and the statutory authorities. It provides information on the social services, carries out research on problems of social work, encourages international co-operation between social workers, promotes, and sometimes undertakes, experiments in social service, provides a headquarters for certain representative organisations, and administers, and advises on the administration of, grants-in-aid from Government departments and charitable trusts. The Council aims at bringing about two forms of co-operation between organisations concerned with different forms of social and community service in the same area, and co-operation between organisations carrying out the same work in different parts of the country. Ideally the two should supplement each other, so that, for example, an Old People's Welfare Council in a particular area is linked on the one hand with its local Council of Social Service, and, on the other, with its County or Regional Old People's Welfare Committee, and through this, with the National Old People's Welfare Committee, which in its turn is linked with the National Council of Social Service, to which the local Council is affiliated through the Standing Conference of Councils of Social Service.

There are, of course, certain dangers to be guarded against in constructing such elaborate co-ordinating machinery. It may result in conformity at the expense of originality, or the dominance of the central administration, and there is always the danger of accepting the appearance of co-operation for its reality. Affiliation to a local or national body does not constitute co-operation if it means nothing more than the payment of an annual subscription, an invitation to an annual meeting, or the perusal of an annual report. If real co-operation is to be brought about, the National Council and its associated regional and local bodies must encourage individual statutory and voluntary agencies to lift their eyes from their own specialist tasks; must enable them to see these tasks in relation to the needs of their locality and the nation as a whole, and inspire them to take co-ordinated action to meet these needs.

Co-operation of this kind results not only in the smoother working of existing services, but in the promotion of new ones, for an alert Council of Social Service or Community Council is sensitive to the developing needs of its area, and ready to discern the gaps left by existing organisations in their haphazard growth.

The chief means used by the National Council of Social Service to promote co-operation on an area basis are the Rural Community Councils in country areas, and the Urban Councils of Social Service in the towns. The Council has long taken a particular interest in the welfare of the countryman and the effects of the changes taking place in the countryside. It believes that 'the methods of consultation and working together for which it stands have special value in this country work, where the scope is large, and the pooling of resources is a very practical necessity'.[1] Its rural development policy has five main objectives, namely to establish in each county a representative council (the Rural Community Council) competent to survey the whole field of rural social life and to promote co-operation between statutory and voluntary agencies taking part in it; to help and encourage villagers to provide halls for themselves; to co-operate with other bodies in the provision of amenities; to increase the effectiveness of parish councils, and to support the county craftsman.[2] At present such co-ordinating councils are functioning in thirty-three administrative counties, and the rural work of the Council is developing steadily with the encouragement of H.M. Development Commissioners and the appropriate local authorities.[3]

The promotion of Urban Councils of Social Service was the first task undertaken by the National Council, but it did not prove an easy or particularly rewarding one, and has tended to be overshadowed by more spectacular activities. In October 1946, when an attempt was made to revive interest in this particular work, and a Standing Conference of Councils of Social Service was set up, only forty-one local Councils were found to be eligible for membership. Even in those towns and cities where bodies describing themselves as 'Councils of Social Service' exist, they vary greatly in the services they provide and the part they play in the life of the local community. According to the sponsors of the movement they should be centres of information about the differing agencies, statutory and voluntary, engaged in social work in their area; they should provide facilities for joint consultation and action; arrange conferences, lectures and exhibitions; and encourage new social experiments, either by assisting other agencies, or, where there is

[1] *A Challenge to the Citizen.* Annual Report of the National Council of Social Service, 1946–7. [2] Ibid.

[3] *Opportunity and Initiative.* Annual Report of the N.C.S.S., 1948–9, pp. 30–6.

no one else able to accept responsibility, by undertaking the work themselves.[1]

The functions of an Urban Council of Social Service may thus be very varied, and its executive committee and officials have to be ever on the alert lest, on the one hand, it concentrates on one or two aspects of its work to the detriment of the rest,[2] or, on the other hand, allows itself to be saddled with the responsibility for a large number of unrelated services simply because no other body is able or willing to do anything about them. In either case the unity and sense of proportion which should be characteristic of the Council's work may easily be lost, and it is in danger of sacrificing its role as a co-ordinating and promotional body, and of becoming one among many organisations specialising in certain types of social work. Ultimately the success of a Council of Social Service depends on the extent to which it enjoys the confidence of the specialist agencies and of the central and local government departments in its area, so that they will consult it when new developments are envisaged, or new needs, for whose satisfaction joint action is required, become apparent. This will only happen if, as well as showing itself efficient in the ordering of practical affairs, and in the administration of those services for which it has assumed special responsibility, it continues to promote 'collective thinking' on current social problems, and this important activity should never be neglected in favour of what seem to be more urgent and useful tasks.[3]

Before leaving the question of co-operation between different agencies working in the same area, mention should be made of the possibilities of co-operation in the raising of the money required to enable them to carry on their work. Of recent years finance has been one of the most serious problems facing voluntary organisations, and renewed attention has been paid to the American expedient of the Community Chest.[4] Such Chests are found in nearly all the important centres of population in U.S.A. and Canada. They vary somewhat in organisation, but present certain general

[1] N.C.S.S., *A Local Council of Social Service*, 1944, pp. 8–9.

[2] This temptation is particularly great when a Council undertakes case work or runs a Citizens' Advice Bureau, since the day-to-day demands of these activities are particularly insistent.

[3] Ibid., p. 12. Cf. Sir Herbert Thompson (General Secretary, London Council of Social Service): 'If, therefore, it is to fulfil its aim no Council of Social Service can be content with case work however excellent, and co-ordination, however necessary. To serve the democratic body it must also think, weigh, study and inspire.' Councils of Social Service and Democracy. *Social Service*, June–August 1950.

[4] For a clear and interesting discussion of this method of money raising, and its effect on social policy, see Ellinor I. Black: 'Community Chests—What are they?' *Social Service*, Vol. XXIV, No. 1, June–August 1950, pp. 6–11.

features. Each year the participating organisations, who must be accredited voluntary bodies fulfilling certain conditions, send copies of their accounts and any other information required, together with estimates of expenditure for the ensuing year, to a budgeting committee which on the basis of this information sets the target for the year's campaign, and afterwards allocates the money collected. Publicity and campaign committees are responsible for making the community aware of its social services, and for planning and organising the annual drive for funds, which is a noticeable feature of this method of collective money-raising.

Such schemes have manifest advantages, but they are open to criticism in certain respects. Thus, an experienced English social worker, Miss Elizabeth Handasyde, who has recently been studying community organisation in U.S.A., states that in the course of her visit she heard some budgeting committees criticised on the grounds that they 'were too ready to accept the targets proposed as reasonable by the business community rather than estimating for themselves the actual needs of the agencies concerned'. Moreover, although established agencies were on the whole satisfied with the work of the Community Chest in their area, pioneer agencies sometimes found it difficult to get accepted as Chest members, and some Settlement workers said that 'they felt themselves hampered in undertaking changes of any significance by the need to justify their proposals to a Budget Committee which expected them to proceed on more or less stereotyped lines'.[1] These criticisms indicate dangers to be avoided, but do not invalidate the general principles underlying the Community Chest movement, and would seem to be outweighed by the advantages of such schemes.[2] Such advantages include the avoidance of competition between agencies; the effect of Chest membership in raising the standard of any participating organisations, and those anxious to be affiliated; and, not least, in educating the public in the need for the continuance of the voluntary services and in fixing responsibility for their maintenance upon the community as a whole.[3]

This distinctively American method of money-raising would, no doubt, have to be modified in some respects to make it workable here, but the general idea of the joint collection and overall budgeting is one which is well worth considering, especially as drastic action is necessary if the voluntary organisations are to overcome

[1] Elizabeth Handasyde, *City or Community*, N.C.S.S., 1949, pp. 16–17.

[2] Liverpool started a Joint Finance Fund in 1953. It is organised by a representative body, United Voluntary Organisations. Income is raised by voluntary contributions of 1d. per week from employees, which is deducted with their consent from salaries or wages, and is to be distributed annually to member charities.

[3] E. I. Black, op. cit., p. 10.

their present financial difficulties.[1] Local Councils of Social Service are well fitted to take the lead in initiating experiments in their own areas, for such joint action is essentially an expression of a real sense of common purpose, showing itself in willingness on the part of all participating to substitute co-operation for competition, and to consider the claims of others as well as their own, and this is directly in line with the main objects of these Councils.

Fostering co-operation between specialist agencies in particular areas by means of Urban Councils of Social Service and Rural Community Councils is one function of the National Council of Social Service; complementary to it is that of promoting co-operation between people and agencies engaged in similar work in different areas. Two examples of such work are the bringing together of local groups striving to foster the growth of community life on housing estates through the National Federation of Community Associations, and the promotion of co-operation at all levels in the very different field of old people's welfare. Moreover, in these, as in other branches of the Council's work, such as the welfare work carried out among the unemployed during the depression between the wars, and the organisation of clubs for women of the lower income groups, the National Council has done more than foster co-operation between existing organisations. Much of its energy has been directed to the promotion of new services as the need for these has become manifest, and in this its task has been threefold—first, the encouragement and canalisation of local effort in different areas throughout the country; secondly, the linking of local committees by means of a national council or standing conference, and thirdly, the provision of specialist help and advice to ensure the maintenance and, where necessary, the improvement of local standards. Local committees dealing with special services remain autonomous and free to accept or reject the help offered by the Council, but in some fields of work it has been able to apply a powerful economic sanction, since it has been made the agency for the disbursement of certain government funds, and could, therefore, impose conditions and insist on the maintenance of certain minimum standards for those benefiting from this financial assistance. For example, in 1933, when the need for specialized social provision for unemployed persons and their families was at last widely recognised, the government of the day made an experimental grant for this purpose, and asked the National Council of

[1] Compare the proposal made by Lord Samuel to the House of Lords in June 1949, for the establishment of national and local Common Good Funds to be placed in the hands of national or local trustees or the Local Authority for the purpose of subsidising any kind of public amenity for which money is not otherwise available. *Hansard* (Lords), Vol. CLXIII, col. 79, 22nd June 1949. A digest is in an N.C.S.S. pamphlet, *Voluntary Action for Social Progress.*

Social Service to undertake its administration. By 1937 the amount of government money received by the Council had reached the impressive total of £317,688, namely £102,757 from the Ministry of Labour and £214,931 from the Commissioner of Special Areas.[1] Similarly, during the war, the National Council was the agency through which the Ministry of Health gave grant-aid to Citizens' Advice Bureaux, and only Bureaux 'approved' by the Council received this financial aid. Clearly an organisation entrusted with the disbursement of such large sums of public money carries a weight of responsibility and wields considerable power. It is to the credit of the National Council of Social Service that in general it has administered these grants in such a way as to encourage local initiative and individual responsibility.

The use made of the National Council of Social Service in the disbursement of public funds raises the question of the relationship between the voluntary organisation for social service and the State, and no discussion of co-operation in social service would be complete without some reference to this question and to the related one of the respective spheres of public and voluntary social services. Before considering these questions, however, it may be as well to define the term 'voluntary social service' a little more closely. It is used here to denote organised social service activity which is in the main independent of government control—'private enterprise in the service of mankind', as Lord Beveridge describes it.[2] It is not the same as 'volunteer service', which is service undertaken by individuals without remuneration. The volunteer helper may, and frequently is, to be found working in connection with a voluntary organisation for social service, but he may also be found as a school manager, member of an Area Advisory Committee of the Assistance Board, or Hospital Management Committee, or serving on the local council. On the other hand, voluntary organisations may, and do, employ full- and part-time salaried workers, but this does not affect their essential character, which depends on the fact that they owe their existence to the initiative and continued support of individuals and groups and not to the State.

The question of the relationship between the voluntary and statutory social services is not a new one. During the latter part of the nineteenth century and early twentieth century the generally accepted theory as to the respective roles of private philanthropy and public relief was that enunciated by Mr. Goschen, the President of the Poor Law Board, in a Memorandum issued in 1869. This theory, designated by Beatrice and Sidney Webb as 'the parallel

[1] *Voluntary Social Services since 1918*, ch. xii, 'The Finance of Voluntary Social Service', p. 192.

[2] Lord Beveridge, *Voluntary Action*, 1948, p. 322.

bars' theory,[1] divided those seeking help into two main categories, the one to be relieved by voluntary agencies, the other left to the functioning of a strict and deterrent Poor Law. State and voluntary aid were to exist side by side, but there was to be no overlapping, and each case must be dealt with wholly by one or other means of assistance. Various criteria were tried as means of separating the sheep from the goats. In the original minute it was proposed that the wholly destitute be relieved by the Poor Law, those with some but not adequate means of subsistence by voluntary agencies. Later the Charity Organisation Society endeavoured to distinguish between the 'deserving' and 'undeserving'; helping the former and thrusting the latter back on Poor Relief, and when the impossibility of thus exercising the prerogative of the Almighty became clear, they then tried to decide between those who could and those who could not be helped back to economic independence by the case work methods which they were slowly evolving. This attempt at segregation also broke down in practice, and although in 1906 the theory was still sufficiently influential to form the basis of the Majority Report of the Royal Commission on the Poor Law, it gradually became clear that the premises on which it had been constructed were false, and a new basis for demarcating the respective spheres of statutory and voluntary action must be sought.

The Webbs' alternative to the 'parallel bars' theory was that of 'the extension ladder'. This theory was based on an attempt to determine the respective strength and weakness of statutory and voluntary organisations, and is thus a division based on the character of the agency, rather than the nature of the case. Voluntary organisations were regarded as being superior to public authorities in three main ways—in invention and initiative, in ability to lavish unstinted care on particular cases, and in the intensity and variety of the religious influences they could bring to bear on personal character; but public authorities were regarded as superior in that they alone could ensure provision that was universal, complete or continuous, and had the power to force the negligent or irresponsible to fulfil their responsibilities. Hence, the Webbs suggested that public authorities should be responsible for seeing that every individual born into the community was given the opportunity to reach a 'national minimum' of civilised life, and that his obligation to maintain that standard was enforced. The part of the voluntary societies was to raise the standard of civilised conduct and physical health above the comparatively low level which could be enforced by the public authority. Voluntary service would thus be an extension ladder 'placed firmly on the foundation of an enforced minimum standard of life, but carrying

[1] S. and B. Webb, *The Prevention of Destitution*, 1911, p. 225.

onward the work of the public authorities to far finer shades of physical, moral and spiritual perfection'.[1]

The 'extension ladder' theory is more akin to present modes of thought on the relationship between the voluntary and statutory social services than the earlier 'parallel bars' theory, but the rapid growth of the Welfare State during the twenty years since it was enunciated, and the changes which have taken and are taking place in the scope and character of the social services, have led to a good deal of discussion of the whole subject, and the questioning of accepted ideas. The publication within the last few years of three books[2] and numerous pamphlets devoted to its consideration, not to speak of a debate in the House of Lords,[3] gives some indication of the attention which it is now being given.

All discussions of the question stress the importance of the experimental work of the voluntary organisations, and pay tribute to those social pioneers who fought prolonged battles against apathy and prejudice in order to eradicate long-established social evils or provide new services for the benefit of their fellows. The history of the social services provides many instances of the ways in which voluntary effort may prepare the way for State action. For example, long before the appointment by a local authority of the first health visitor, the Manchester and Salford Ladies' Sanitary Reform Association arranged for the visiting of young mothers in their homes by an experienced woman especially appointed for the purpose. Joseph Lancaster founded his school for poor boys in Borough Road East many years before the government of the day considered the education of the children of the nation as a matter worthy of its attention. Similarly the court missionary preceded the probation officer. These are examples from the past, but such experimental work is still going on and some of the services described or mentioned in these pages are of this nature; for instance, the Family Service Units' intensive case work with problem families; the Brentwood Recuperative Centre; the Family Discussion Bureaux, and the Peckham Health Centre. Even experiments that fail, or are only partially successful, may contribute to social progress by showing that what may appear to be a clear way forward is but a blind alley, or that such a method of tackling a problem has unforeseen results and may, in the long run, do more harm than good. Voluntary organisations can more readily run the risk of failure than can the State or local authorities, for these are answerable to the public and are custodians of public money.

[1] S. and B. Webb, op. cit., pp. 240–52.

[2] A. Bourdillon (ed.), *Voluntary Social Service in the Modern State*, 1945. H. Mess and others, *Voluntary Social Services since 1918*, 1947. Lord Beveridge, *Voluntary Action*, 1948.

[3] 22nd June 1949.

Thus, voluntary initiative has played and is still playing an important part in the development of the social services, and in some branches of social work its influence has been decisive.

Generally speaking, central and local government authorities have been slower in initiating wholly new experiments than the voluntary organisations, but they have often shown considerable imagination and enterprise in adapting and developing projects initiated by private enterprise or voluntary action. For example, when once the principle of government support for popular education was accepted, Sir James Kay-Shuttleworth could seek to raise its standards and widen its scope far beyond the rather limited ideas of the National Society and the British and Foreign Schools Society, while as soon as the necessary powers had been obtained Sir Arthur Newsholme and Sir George Newman built up the child health services on a national scale. In some instances, moreover, local authorities have themselves made the initial experiments, even if this has meant obtaining special powers for the purpose. Thus Liverpool may claim the credit for appointing the first Medical Officer of Health, St. Helens for setting up the first infant milk depot, and Huddersfield for introducing the notification of births. Further, some services, to be effective, had to be universal and statutory from the start, and in these cases the work of the pioneer was so to influence public opinion that it sanctioned large-scale state experiment. That this may be a long and wearisome task is shown, for instance, by Eleanor Rathbone's twenty-year struggle to get Parliament to bring in legislation to provide universal family allowances, but such measures for the betterment of the people as old age pensions, the setting up of employment exchanges, and the regulation of wages in certain trades by means of Trade Boards,[1] show what can be done by this means.

It would seem then that ultimately all social advance begins with 'the vision of an inspired individual',[2] but this vision may be translated into reality in more than one way, the precise method used being dependent on the nature of the reform to be brought about, the circumstances and spirit of the times, and the temperament and outlook of the individual who has been moved to set his hand to a particular plough. If progress is to continue it is essential that all concerned with social service in any form—statesmen, administrators, local government officials, as well as secretaries and organisers of voluntary associations, shall be sufficiently open to new ideas to give heed to the voice of the prophet, and enable the pioneer to make his experiments. Both statutory and voluntary bodies can too easily become stereotyped in outlook and method,

[1] These have now been transformed into Wages Councils.

[2] The phrase is taken from B. H. Reed: *Eighty Thousand Adolescents*, p. 147.

and over-cautious in their attitude towards the original thinker, and in this way opportunities for further advance may be lost. The voluntary organisations have perhaps special responsibilities for encouraging new ideas and experiments, but in much of their pioneer work they can enlist the interest and encouragement, if not in its early stages the active support, of the state or local authorities. Then, if the latter respond, co-operation may be brought about from the beginning. Where this has been done[1] difficulties have been avoided, and greater progress has been made.

The special fitness of voluntary organisations for pioneering and experimental work is widely acknowledged, but the question as to whether they should confine themselves to this type of work, handing over those enterprises whose usefulness has become established to the State or local authorities, is a more debatable one. Such self-sacrifice would oft-times seem to be the right course of action, although it may be hard for the voluntary organisation concerned, but there are some forms of social service for whose satisfactory operation voluntary organisations might appear to be intrinsically better fitted than the statutory authorities. Such services they should continue to operate. Thus, in an earlier chapter[2] it was suggested that the provision of an advice service, whether general or legal, is best left in the hands of a voluntary or professional organisation, and, for different reasons, voluntary organisations have a special contribution to make to the service of youth.[3]

Many social workers hold with the Webbs that voluntary organisations are able to handle personal problems with greater delicacy and understanding than the statutory services, and that as far as possible, the various forms of social case work should remain within their province. It is, however, doubtful if this position can be maintained in the face of the recent developments of the statutory services. For example, the nationalisation of the hospitals has meant that numerous almoners and psychiatric social workers who, until July 1948, were working for voluntary organisations, must now function within a statutory framework, but the change does not appear to have lessened their opportunities for real social case work,[4] while the Children Act has created new opportunities for personal work of a most intimate kind. These examples show that employment by a statutory authority does not necessarily mean that the social worker loses her personal

[1] E.g., in connection with Citizens' Advice Bureaux. See Chapter VIII.

[2] Chapter VIII. [3] See Chapter XVI.

[4] As pointed out in Chapter VII, the Ministry of Health regards the nationalisation of the hospitals, which has largely freed the almoner from the necessity of making assessments of the patients' incomes, as providing her with further opportunities for 'the important medical-social work for which she has been especially trained'.

touch. At the same time, the recommendations of the Denning and Harris Committees, the recent proposals of the Ministry of Health to local authorities for co-operation with voluntary organisations in the friendly visiting of old people,[1] and the same Ministry's concern that local maternity and child welfare authorities should seek the help of voluntary organisations in dealing with the personal problems of the unmarried mother and her child,[2] indicate a recognition, on the part of the statutory authorities themselves, that non-official bodies have a real contribution to make in dealing with personal problems, and that their help will sometimes be accepted by people who are suspicious of official visitors, however friendly and sympathetic. It would thus appear to be useless to try to demarcate rigidly the respective spheres of the statutory and voluntary social services in social case work. What is important is to seek to ensure that in so far as they undertake the intimate personal case work, at one time considered to be the special province of the voluntary organisations, the statutory authorities also exercise those qualities which characterise voluntary social service at its best. Furthermore, where statutory and voluntary bodies are working in the same or related fields their relations should be based on mutual co-operation and respect, and not on 'primitive fears of other tigers in the jungle'.[3]

So far the main theme of this chapter has been the need for co-operation, but co-operation does not necessarilymean acquiesence in all that the partner does, and an important, and indeed necessary, function of the voluntary organisations is that of constructive criticism, both of the law itself and of its administration. Much can be done from within a statutory service, and the nation owes a great deal to those civil servants, known and unknown, whose criticisms and suggestions, first embodied in Departmental Reports and Minutes, have ultimately been incorporated in new legislation.[4] At the same time informed and constructive criticism from without may be a valuable stimulus and corrective to any tendency to inertia or complacency on the part of a government department. Hence the value of such voluntary organisations as the Howard League for Penal Reform and the Council for the Unmarried Mother and her Child, which are concerned not so much to help individual cases of distress as to try to bring about radical improvements in the laws and their administration. Moreover, as

[1] Ministry of Health Circular 11/50, *Welfare of Old People.*

[2] Ministry of Health Circular 2866, 1943, *The Care of Illegitimate Children.*

[3] Roger Wilson, 'The Aims of Social Work'. Address given to the British National Conference on Social Work, Harrogate, April 1950.

[4] For example, the Factories Acts incorporate many suggestions first made by local inspectors as a result of their direct observation of conditions.

we have already seen, organisations such as Citizens' Advice Bureaux, whose main work is that of dealing with individual difficulties, are by the very nature of their work in an especially good position to see where the shoe pinches, and have a real responsibility, not only for mitigating hardship in individual cases, but also for pressing for reform. This is an important additional argument for preserving their voluntary character.

Thus, even in a welfare state there are tasks to which private individuals concerned to further the well-being of their fellows may still feel themselves called, and in a recent House of Lords debate on the subject, Lord Pakenham stated quite categorically that the Government was 'convinced that voluntary associations have rendered, are rendering and must be encouraged to continue to render, great and indispensable service to the community'.[1] Yet many such organisations have fallen on difficult times, and are hard-pressed to find the wherewithal to continue their work, since costs are rising, and sources of income drying up. Consequently, they are coming to rely more and more on grant-aid from local authorities and central government departments, and it may be that, except on a very limited scale in pioneer or very controversial work, the days of the strictly voluntary organisation—that is, an organisation working absolutely independently without state or local authority assistance of any kind—are at an end. The emphasis to-day is on partnership, a partnership in which the central government, the local authority and the voluntary organisation all have their parts to play,[2] and in which the State, recognising the value of the work of the voluntary organisation, assists it to play its part. Hence the State and the local authority give financial support to the voluntary body and so help to establish its status as well as making its continued existence possible; in return they make use of the machinery it has built up, and benefit from the tradition it has established. It is an arrangement demanding mutual confidence, and is only possible in a society where the State has confidence in the free association of its citizens. It demands give and take on both sides. There is a danger that on the one hand over-reliance on grant-aid may make impossible that independence of thought and action which is the very life-blood of voluntary social service, on the other hand that a voluntary body so assisted may establish a 'vested interest' in a particular form of social work, and perhaps delay its transfer to a more efficient method of administration. If these dangers can be avoided, such

[1] 22nd June 1949. Parliamentary Debates (Lords) *Hansard*, 5th Series, Vol. CLXIII, col. 119. The whole debate is of interest.

[2] This is stated specifically in such pronouncements as Circular 1486, *The Service of Youth.*

state assistance to voluntary organisations has the advantage of encouraging variation and experiment, while ensuring minimum standards, since aid from public funds necessarily carries with it some provision for seeing that standards are maintained.

Grant-aid is but one means by which the central government or local authorities can assist voluntary organisations concerned with social service. The provision of specialist advice and help, such as that often given by Local Education Authorities to voluntary youth organisations is another, the loan of premises and equipment is a third. These may seem small things, but it is in the handling of concrete situations in particular localities that the reality behind high-sounding phrases about cooperation and partnership can, if it exists, find expression, and a sense of common purpose issue in action resulting in achievements of lasting value to the community.

CHAPTER XXII

THE WELFARE STATE

'Wherever there is lost the consciousness that every man is an object of concern for us just because he is a man, civilisation and morals are shaken and the advance of fully developed inhumanity is only a question of time.'—ALBERT SCHWEITZER.

'For the life of this City is, through and through, a life of fellowship.'—ST. AUGUSTINE, *De Civitate Dei.*

In a challenging article published in *The Manchester Guardian* on 30th December 1950, Mr. A. J. P. Taylor contrasts the nineteenth century, the Age of Hope, with the twentieth century, the Age of Hope Fulfilled, but also the age in which fulfilment has brought disillusionment rather than satisfaction, peril rather than security, and faced us with the necessity of rethinking the values out of which the hope sprang. How far is this true of the advances in social welfare which have been among the most notable developments of the twentieth century and which it has been the purpose of this book to describe? It can truly be said that we have reached the end of an era in social policy, since, as a result of a struggle lasting a century or more, *laissez-faire* has been superseded by the 'Welfare State'. Moreover, having entered into our heritage, we are conscious of its drawbacks as well as its advantages, its limitations as well as its achievements, and we must explore these further before we can assess, even tentatively, the value of the organisation we have built up, and plan constructively for the future.

The distinguishing characteristic of the Welfare State is the assumption by the community, acting through the State, of the responsibility for providing the means whereby all its members can reach minimum standards of health, economic security and civilised living, and can share according to their capacity in its social and cultural heritage.[1] It is true that as yet our performance lags behind our intentions in these matters, and there is much to be done before even the most elementary requirements of civilised living are within reach of all. 'High-falutin' phrases about social

[1] Cf. T. H. Marshall, *Citizenship and Social Class*, p. 11, the definition of the social element in citizenship.

medicine are all very well; we in Salford still have the school lavatories to attend to', wrote Dr. J. L. Burn, School Medical Officer of that city, in a recent annual report,[1] and in almost every town unhygienic school buildings can be matched with overcrowded and insanitary dwellings and unsatisfactory workshops. But, as this quotation from Dr. Burn's report shows, we now recognise that these are things which must be attended to, and the bitter paradox of the continued existence of preventible ill-health, poverty and squalor in a State which dares to call itself a 'Welfare State' is in the main due to defects in planning and administration, to failure to overcome financial and technical difficulties, and to the competition between the claims of welfare and other aspects of national policy such as rearmament for an adequate share of national resources, rather than refusal to accept responsibility for all that concerns the well-being of the people. For example, in all the recent debates on housing the responsibility of the Government to provide a sufficient number of fit houses for the families of the nation has been taken for granted by all parties—the debates have centred on the effectiveness with which this responsibility is being discharged, and the extent to which housing needs should have priority over other claims for our limited resources in money, manpower and materials. The Welfare State has still much 'unfinished business'[2] on its hands, but it is here and is prepared to tackle it.

As we have already seen in previous chapters, the expansion of our social services culminating in the conception of the Welfare State, has been spasmodic and empirical, based on response to immediate needs rather than on ordered development resulting from the putting into practice of clearly thought out principles. Nevertheless, in and through the chequered history of these services we can trace the emergence of a fuller, if still imperfect, understanding of the implications of two beliefs—belief in the intrinsic value of human beings because they are human, and belief in the reality of community.

The first of the beliefs is well summed up in the dictum of the Commonwealth soldier, Colonel Thomas Rainborough, that 'the poorest he that is in England has a life to live as the greatest he', and whatever Colonel Rainborough meant by 'poorest' we now interpret it to mean poorest in mental or physical endowment as well as poórest in this world's goods. Thus we give all the advantages we can even to those whom we know will never make the community a return commensurate with the expense and care lavished

[1] City of Salford Education Committee, *School Health Service*—Report of the School Medical Officer for the year ended 31st December 1948.

[2] This phrase forms the chapter heading of the last chapter of Professor Titmuss' book, *Problems of Social Policy*.

on them. For example, we seek to provide the idiot and hopelessly crippled with opportunities for developing their limited capacities to the uttermost as well as seeing that the able boy from a poor home is given the opportunity of obtaining a university education, while concern for the welfare of old people developed markedly during the war, although as a group they were of little actual or potential value to a nation engaged in a struggle for survival. It may be that the policies of the Welfare State are too limited in their understanding of human needs and aspirations, and this is a point to which we shall return later in the chapter, but at the heart of these policies is concern for individual well-being based on a belief in individual worth.

Respect for a person as such is basic to social work, but it takes into account only part of the truth about human beings and human life. We do not live by or unto ourselves alone, but in relationship with others. It is in and through relationships that personality is developed to its full, while the network of relationships so created forms the basis of society.[1] One of the most serious effects of the economic and social dislocations and regroupings which accompanied the Agrarian and Industrial Revolutions was that they tended to break up neighbourhood and kinship bonds, and subordinate all other ties which bind men together to that of contract, and from one point of view the development of the social services in the nineteenth and the twentieth centuries may be regarded as a reassertion of community solidarity and community obligation against the disintegrating influences of our modern industrialised society.[2] This is seen, for example, in the change which took place during this period in the community's attitude to those who, unable to support themselves, turned to it for succour. When the Poor Law Amendment Act was passed in 1834 individualism was in its heyday. The race was for the strong, and the man who fell out was the object not so much of pity as contempt, for his failure was regarded as being due in large measure to his own weakness or folly. He could not be allowed to suffer physical death, but he ceased to belong in any real sense to

[1] Cf. 'The truth seems to be that a human society is in itself a system of relationships between human beings who are not only individuals but are also social animals in the sense that they could not exist at all without being in this relationship to one another'. Arnold J. Toynbee, *A Study of History*, abridgment of Vols. I–VI by D. C. Somervell, p. 211.

[2] It was not the only such assertion. Another important one was the development of mutual aid through such organisations as friendly societies, trade unions and the Co-operative movement. Owing to the necessity of limiting the subject matter of this book to manageable proportions these have received less attention than they merit. The influence of friendly societies is discussed at some length in Beveridge, *Voluntary Action*.

the normal community of self-respecting citizens. He became 'a marked person, all of whose social relationships, if they continued at all, were on sufferance';[1] he had crossed the road 'that separated the community of citizens from the outcast company of the destitute'.[2] To-day the applicant for relief is regarded as one who has a special claim on community resources and community care—whose welfare must be the first concern of those who are appointed to supply his needs.[3] These developments can be paralelled in other spheres of social service[4] and we have come to see that, in Winifred Holtby's words, such collective action is 'in essence the first-line defence thrown up by the community against our common enemies—poverty, sickness, ignorance, isolation, mental derangement and social maladjustment . . . and this corporate action is at least based upon recognition of one fundamental truth about human nature—we are not only single individuals each face to face with eternity and our separate spirits; we are members one of another'.[5] The Welfare State is a witness to the reality of our belief in community, as well as to our belief in the claims of the individual.

The development of the social services and their integration in the Welfare State are then the outcome of the application of certain fundamental beliefs about the value of people as people, and the significance of their relationships with each other. But the coming into existence of the services has, in its turn, influenced people's attitudes and relationships, and it is now necessary to consider the changes that are taking place. As Professor T. H. Marshall notes in his essay, *Citizenship and Social Class*, an important effect of the coming of the Welfare State has been to invest the individual with 'social rights' to set alongside his civil and political rights. The result of this is that his well-being is coming to depend more on his status of citizen and less on the amount of money he earns. When universal social services are combined with controls, rationing and high taxation, the effects of inequalities in money income decrease, and show themselves in the ability to afford non-essentials rather than the possibility of obtaining the essentials of life. Over much of life 'the provided service and not the purchased service becomes the norm of social welfare'.[6]

From many points of view this is a worth-while achievement. It means 'a general reduction of risk and insecurity' and 'an equalisation between the more and less fortunate at all levels',[7] and so

[1] Roger Wilson, *Social Work in a Changing World*, 1950, p. 6.
[2] T. H. Marshall, *Citizenship and Social Class*, 1950, p. 24.
[3] National Assistance Act, 1948, Section 2 (2). See above, Chapter III.
[4] These are described by Roger Wilson, op. cit.
[5] Preface to *South Riding*. [6] Op. cit., p. 58. [7] Ibid., p. 56.

takes us a long way towards the establishment of a more just society. But all this is obtained at a price. Even when adjusted to the needs of the individual, the provided service tends to become a standardised service, and the extension of such services reduces the area over which free, or relatively free, choice may be exercised. Moreover, as the individual makes use of these services, he places himself in the position of a recipient, playing a passive and dependent role rather than an active and initiating one, while the power of the official is correspondingly increased. In the long run the consequences of this may be serious, since it is largely through the exercise of choice and the acceptance of responsibility that a person becomes fully adult.

It may, of course, be suggested that the unskilled labourer of the nineteenth century, uneducated, tied to a monotonous job, and so badly paid that he was barely able to obtain even the necessities of life, had little real freedom and few opportunities for the development of his potentialities, and those who suffered and fought to bring in the welfare state were actuated by the desire to free him from this bondage. The problem which we, as a community, have not entirely solved is how, having gone some way towards freeing our fellow-citizens from anxiety, poverty and unremitting toil, we can prevent our efforts in this direction from resulting in over-dependence on the State. Pointers towards the solution of this problem may be seen perhaps in the importance which is becoming increasingly attached to the growth of active community life involving a share in the responsibility for the provision of neighbourhood services and the preservation of neighbourhood amenities;[1] in the encouragement of various forms of industrial democracy, and in the emphasis placed by social and health workers on the need for the active co-operation of the individual or family concerned if their rehabilitation is to be achieved. But these are only pointers, and we are still seeking the means of finding further scope for the active and democratic participation of the citizen in the community planning and community service from which he benefits.

Closely akin to the question of the influence of the development of the Welfare State on personal freedom and responsibility is that of its effects on the status and functions of the family. In one form or another the family is found in all types of society, but its characteristics and function, and its importance as compared with other social institutions, vary from one culture to another. In most societies unaffected by industrialisation its functions include the provision of the necessities of life for its members, the care and

[1] See Chapters VI and XX, above.

comfort of the aged and the nurture and education of the young. These functions are, however, frequently shared by the whole kinship group and not borne entirely by the small conjugal family. In our modern western civilisation many forces are at work the effect of which is to threaten the unity and reduce the status of the family. Thus the factory system has removed industry from the home and made the individual wage-earner rather than the family the economic unit; mass-production techniques and labour-saving devices have lessened the burden, but at the same time led to a decline in the variety and dignity of domestic tasks and achievements, and women are encouraged to go out to work and find leisure-time interests outside the home. Increased mobility has broken up local communities and kinship groups, and the refinement of contraceptive techniques has made both the size and spacing of the family increasingly a matter of choice. It has also made it possible to sever the age-old connection between sexual intercourse and child-bearing and rearing, the biological basis of family life. Yet, in spite of these disruptive influences, the ties which bind members of a family together remain stronger and more enduring than is always recognised. This was shown during the war when members of families preferred to face the dangers and discomforts of aerial bombardment together, rather than experience the strains and anxieties of separation.[1] It is against this complex background that the influence of the social services on the family must be studied.

Some students of social affairs hold that the development of the social services should be included among the economic and social processes whose effect has been to weaken the influence of the family. Thus the Royal Commission on Population sums up its discussion on *Social Policy and the Family* by saying, 'In the process of social advance, until recently, the family has been overlooked or given only a minor place in social policy . . . and the over-all effect has been to lower the status of the family in the national life'.[2] Support for this contention may be found in the extension of such services as day nurseries and school meals which enable a mother to go out to work, but do not encourage her to create a home for her children; the narrowing of responsibility for mutual care under the National Assistance Act, and the extension of facilities for recreation outside the home by such provisions as play centres and boys' and girls' clubs. The object of all these provisions is the welfare of the individual, and it is suggested that in furthering this family ties and obligations are being undermined,

[1] For evidence of this, see R. M. Titmuss, *Problems of Social Policy*, chs. x and xvii.

[2] Op. cit., p. 151, par. 406.

and in the long run this is detrimental to both individual and corporate well-being.

This indictment of the social services contains an element of truth, but is far from being the whole truth. The welfare of the individual must be the State's paramount concern, and, as a last resort, the community must have the power to step in and protect the immature and helpless from the cruelty or indifference of their own relations.[1] With these reservations, however, it should frame its laws in such a way as to preserve such groupings as the family and neighbourhood as far as possible. This appears to be implicit in much recent social legislation, for this would seem to be designed to ease the economic and other environmental stresses from which many families are suffering and so help preserve their unity. An example of legislation of this type is the family allowance scheme[2] while the importance attached to housing policy is another indication of the concern of the community that a satisfactory home life shall be possible for all its members.

While the family as a unit and the values enshrined in family life, such as mutual support and care resting on mutual affection, can and should be encouraged, they can be overstressed and impose intolerable strains on individuals. In these cases, such as that of the daughter who, with the assistance of a home help or a district nurse, and with the possibility of an occasional holiday, may care for an aged or infirm parent for a long period without having to undergo the virtual incarceration which many suffer now,[3] community provisions may help to ease the burden, and so enable obligations of family affection to be maintained without the sacrifice of the individual. Such support is important not only to preserve the mental and physical health of individuals, but in the interest of good family relationships.

A further contribution to the preservation and maintenance of healthy family life is made by those social services which, while they do nothing to abate the responsibility of the persons concerned, endeavour to inculcate higher standards, especially if, at the same time, they provide expert advice and technical assistance, which will enable the families helped to reach and maintain these standards. The maternity and child welfare service is a good example of this, but all case workers, whatever the service to which they are attached, stress the fact that their role is to support and advise, but ultimate responsibility rests with the family itself. Thus

[1] This is shown, for example, in the story of the development of the services for the neglected and ill-treated child described in Chapter XIII.

[2] For more detailed discussion of this point see Chapter II, above.

[3] For examples see J. H. Sheldon, *The Social Medicine of Old Age*, pp. 27–9 and 181–5.

the probation officer in his dealings with the parents of the young delinquent; the psychiatric social worker guiding the mother of a maladjusted child towards a better understanding of his difficulties; the marriage guidance counsellor advising a young couple who are finding adjustment to married life more exacting than they had expected; the family case worker patiently helping a problem family back to self-respect and independence—each and all are deeply concerned to maintain, and where necessary restore, the integrity and unity of the family, and only as a last resort when all their resources and techniques have failed will they recommend measures that would involve the separation of the marriage partners and alternative forms of care for the children.

Hence, while it cannot be denied that the existence of the social services fosters the tendency of some individuals and families to seek outside support and assistance, when with a little more effort and initiative and some mutual assistance they could perhaps cope with their difficulties unaided,[1] at the same time this is something which most social workers would deprecate and seek to overcome, since they are concerned that the social services should be a means of releasing the potentialities of individuals and groups, rather than an excuse for increased dependency. The difficulties of achieving this constructive aim are considerable, however, as the determination to obtain as much as possible from the State, while contributing as little as possible to it, appears to be widespread among the general public, as well as among the chronically dependent, and even people who regard themselves as good citizens look upon it as normal and right. It shows itself in such anti-social practices as tax evasion and extravagant claims for expenses, as well as in abuse of the Health Service and in the concealment of resources from the National Assistance Board. It is thus a problem of morale in which the whole community, and not only a section of it, is involved. Its import is grave, since if the Welfare State is to remain free and democratic, it will demand high standards of responsibility and integrity from its citizens. Should we be unable to accept and maintain these standards, then the choice would seem to be between returning to the acquisitive society of the past and retaining such freedom as it offered, and sacrificing liberty in order to retain welfare.[2] As individuals and as a society we shall only have the inspiration and determination to overcome this

[1] For example, Children's Departments complain that they are frequently asked to take children into temporary care when there is really no need as there are relatives who could help. Gwyneth M. Haynes-Thomas, 'Work in a Children's Department in the North-west', *Quarterly Bulletin of the Society of Housing Managers*, Vol. III, No. 1, January 1951, p. 7.

[2] Cf. F. R. Barry, *The Recovery of Man*, p 89.

dilemma, and maintain all that is best in both the liberal tradition of the past and the silent social revolution of the present if we are convinced that, in spite of inevitable imperfections, what has been and is being accomplished in the way of social advance is of real and lasting worth, that it is not merely a panacea for present ills, but holds promise for the future.

Can the objectives and achievements of the Welfare State pass this test? In the main it is associated in men's minds with establishment of minimum standards of economic security and of health and decency. The establishment of these standards is solid gain, but it may be felt that if this is all the Welfare State has to offer, the incentive to increased effort and greater self-discipline is insufficient. 'It has become evident', states the Social and Industrial Commission of the Church Assembly in its discussion of the reasons underlying the present-day prevalence of gambling, 'that social security in whatever degree or manner it may be justifiable as an aim of social planning can never be the goal of human satisfaction. It gives men solid ground beneath their feet but it cannot of itself fulfil the aspiration of men's hearts and minds.' This is the verdict of a group of churchmen. It may be compared with an artist's judgment on Letchworth Garden City, the embodiment of so much of the practical idealism of our times. 'Why', William Townsend asks, 'should we find it so supremely unsatisfying, however many admirable things there are about it?' And in answer to his own question he says, 'But it does lack the marks of tension, of doubt, of struggle of any kind. It misses, on the other hand, the large acceptance of life. As a prospect, as urban landscape, it is just miles and miles of pleasant cosiness.'[1] If 'cosiness' and 'security' are all that the Welfare State has to offer its citizens the end may indeed be frustration since 'When society is directed by purely utilitarian motives it lacks an inner dynamic'.[2] Freedom *from* is insufficient, and if we know of no Celestial City to which to direct our steps when we have overcome the giants of Want, Squalor, Disease, Ignorance and Idleness, we may well find ourselves in By-Path Meadow heading for Doubting Castle.

In overstressing its concern for material well-being we shall do less than justice to the Welfare State, however, since there are signs that, having tackled the worst evils of poverty, squalor and disease we are becoming increasingly sensitive to man's less tangible but equally vital social and psychological needs. This is shown, for example, in our concern for mental as well as physical health, in our stress on the child's need for affection and security as well as

[1] William Townsend, 'The First Garden City, a Painter's Impression of Letchworth', *The Listener*, 23rd November 1950.

[2] Karl Mannheim, *Diagnosis of Our Time*, p. 123.

physical care, in our emphasis on the value of good human relations as well as good physical conditions in industry and employment, and in the value we place on provisions for community life in planning our new towns. The recognition of these needs is the first step towards a broader conception of welfare which will give us greater inspiration in the present and a more positive goal for the future.

This increased sensitivity owes a great deal to the twin sciences of psychology and sociology which have grown and changed beyond recognition during the last hundred years. The value of the greater understanding of ourselves and our fellows which social science gives us is inestimable, but this does not necessarily mean that the application of the objective methods of natural science to the study of man and his relationships in society is all that is necessary for individual and social salvation.[1] 'No social scientist who has been closely in touch with the uses of social science in World War II . . . can doubt that awareness and understanding can be used destructively as well as constructively, that social science in itself carries no guarantee of good to mankind any more than theoretical physics does. . . . Pursued without responsibility either may lead to evil as easily as to good.'[2] Nor is it established that the scientific method can by itself unveil the whole truth about human nature or give meaning to the whole of experience.

Science can make a valuable contribution to our understanding of man's deeper needs, but cannot of itself fully comprehend and satisfy the aspirations of his heart and mind, or by itself provide a complete guide to social policy. If that is so, what more is needed? 'If I know all mysteries and all knowledge, and have not love, I am nothing', wrote St. Paul, and if we are to create a society in which we and our fellows may find both freedom and fellowship, then the deeper understanding of ourselves and our fellows which increased knowledge gives us must be informed and accompanied by greater love. This requires of us what Albert Schweitzer calls 'reverence for life' —an acceptance of ourselves and of others which excludes all desire to dominate and possess and expresses itself in co-operation for the common good. To love one's neighbour as oneself in this way does not come easily, however. It has been proclaimed as part of the Christian gospel for nearly two thousand years and there have always been those who have sought both to discover its implications and practise them in their lives; but both as a doctrine and a way of life it has constantly been perverted, ignored and even re-

[1] This appears to be the claim made in Professor Barbara Wootton's *Testament of Social Science*.

[2] Margaret Mead, 'The Ethics of Insight Giving', Appendix II to *Male and Female* (Victor Gollancz Ltd., 1950), p. 432.

jected. Yet to do this leads ultimately to the disintegration of man and society, while acceptance brings new and more abundant life, which involves new challenges, new tasks and new responsibilities. The tasks and responsibilities which love's service imposes differ from man to man and generation to generation. In the nineteenth century its acceptance challenged men and women like Lord Shaftesbury, Benjamin Waugh, Josephine Butler, and others who, while they did not profess and call themselves Christians, were led by the same spirit, to free their fellows from gross injustice, cruelty, oppression and poverty; in the second half of the twentieth century the same ethic should inspire us to use this freedom which has been won for us, and the greater knowledge of man and society which the scientist's patient search for the truth has brought, for the enlargement of men's minds, the sweetening and strengthening of their relationships, the healing of their divisions. Failure to recognise and respond to this challenge from within may in the long run be as serious a threat to our civilization as danger from without. Acceptance, even if our achievements fall short of our aspirations, will bring encouragement to those who, in different parts of the world, and in ways adjusted to the needs of their own culture, are seeking, often in circumstances of the greatest difficulty, to establish and maintain free co-operation based on respect for the individual as the basis of society, and this is the new task of the heirs of the Welfare State.

SUGGESTIONS FOR FURTHER READING AND REFERENCE

THIS book was written as a general introduction to the study of the social services, and should be read in conjunction with the government publications, reports of Parliamentary debates and specialist literature dealing with the topics covered. The list which follows is not exhaustive, but it includes a number of published works likely to be useful to the general student.

When consulting books, pamphlets or works of reference the *date of publication* should be carefully noted, as owing to the changes which have taken place in both social legislation and general social and economic conditions of recent years, and which are still in progress, literature dealing with these subjects quickly becomes out of date. At the same time a book or other document should not be left unread simply because it was written some years ago. Even if out-dated in detail it may contain important discussions of principle which are still relevant, or describe conditions and events a knowledge of which is necessary for a proper understanding of the present situation. Some of the older books mentioned are now out of print, but can be consulted in libraries.

Central and Local Government

Some knowledge of the structure and functioning of both central and local government has been assumed throughout this book. The following references may prove useful for those who are not familiar with these subjects.

W. I. Jennings: *The British Constitution.* Cambridge University Press, 1941. New edition, 1946.

W. Harrison: *The Government of Britain.* Hutchinson's University Library, 1948.

T. A. Critchley: *The Civil Service To-day.* Victor Gollancz Ltd., 1951.

W. E. Jackson: *The Structure of the Local Government of England and Wales.* Longmans, Green & Co., 1949.

E. C. R. Hadfield and J. E. MacColl: *British Local Government.* Hutchinson's University Library, 1949.

K. B. Smellie: *A History of Local Government.* George Allen & Unwin, 1946.

Historical Background

Some knowledge of changes which have taken place in social and economic conditions since the Industrial Revolution is essen-

tial if the development of the social services is to be understood. The following books will be found useful in this connection:

G. M. Trevelyan: *English Social History*. Longmans, Green & Co., 1944.
T. S. Ashton: *The Industrial Revolution 1760–1830*. Home University Library, Oxford University Press, 1948.
J. H. Clapham: *The Concise Economic and Social History*. Cambridge University Press, 1950.
G. D. H. Cole and Raymond Postgate: *The Common People, 1746–1946*. Methuen & Co. Ltd., new and revised edition, 1946.
J. L. and Barbara Hammond: *The Village Labourer*. First published 1911. Guild Books, two volumes, 1948.
The Town Labourer, 1760–1832. First published 1917. Guild Books, two volumes, 1949.
The Bleak Age. First published 1934. Revised edition, Pelican Books 1947.

Biographies

The biographies of men and women whose work and thought have laid the foundations of the social services as we know them make stimulating reading, and we can learn much about earlier social conditions and the influences which brought about social change from them. Hence the inclusion of the following books:

Betsy Rodgers: *Cloak of Charity—Studies in Eighteenth-century Philanthropy*. Methuen & Co., 1949.
Janet Whitney: *Elizabeth Fry, Quaker Heroine*. George Harrap & Co. Ltd., 1937.
J. L. and Barbara Hammond: *Lord Shaftesbury*. First published 1923. Pelican Books, 1939.
Barbara Blackburn: *Noble Lord. The Life of the Seventh Earl of Shaftesbury*. Home & Van Thal, 1949.
Cecil Woodham Smith: *Florence Nightingale*. Constable, 1950.
Frank Smith: *The Life of Sir James Kay-Shuttleworth*. John Murray, 1923.
Henrietta Barnett: *Canon Barnett, His Life, Work and Friends*. 1921.
E. Moberley Bell: *Octavia Hill, a Biography*. Constable & Co., 1942.
George and L. A. Johnson: *Josephine Butler*. 1911.
A. E. Williams: *Barnardo of Stepney*.
Rosa Hobhouse: *Benjamin Waugh, Founder of the National Society for the Prevention of Cruelty to Children*. C. W. Daniel Company Ltd., 1939.
Beatrice Webb: *My Apprenticeship*. First published 1926. Pelican Books, two volumes, 1938.
Our Partnership. Edited by Barbara Drake and Margaret I. Cole. Longmans, Green & Co., 1948.
Margaret Cole: *Beatrice Webb*. Longmans, Green & Co., 1945.
D'Arcy Cresswell: *Margaret McMillan. A Memoir*. Hutchinson & Co., 1948.
Mary Stocks: *Eleanor Rathbone*. Victor Gollancz Ltd., 1949.

SUGGESTIONS FOR FURTHER READING

The Development of the Social Services

H. and M. Wickwar: *The Social Services, an Historical Survey.* Second edition, revised, Bodley Head, 1949.

T. S. Simey: *Principles of Social Administration.* Oxford University Press, 1937.

Richard M. Titmuss: *Problems of Social Policy. History of the Second World War.* U.K. Civil Series. H.M.S.O. and Longmans, Green & Co., 1950.

Emmeline W. Cohen: *English Social Services, Methods and Growth.* George Allen & Unwin, 1949.

T. H. Marshall: *Citizenship and Social Class.* Cambridge University Press, 1950.

Surveys of Social Conditions

B. Seebohm Rowntree: *Poverty, a Study of Town Life,* Macmillan & Co. Ltd., 1901.

Poverty and Progress: A Second Social Survey of York. Longmans, Green & Co., 1941.

B. Seebohm Rowntree and G. R. Lavers: *Poverty and the Welfare State: A Third Social Survey of York.* Longmans, Green & Co., 1951.

A. M. Carr-Saunders and D. Caradog Jones: *The Social Structure of England and Wales.* Oxford University Press. Second edition, 1937.

Margery Spring Rice: *Working Class Wives.* Pelican, 1939.

Women's Group on Public Welfare: *Our Towns, a Close-up.* Oxford University Press, 1943.

Report of the Royal Commission on Population. Cmd. 7695. H.M.S.O., 1949.

Papers of the Royal Commission on Population:

Vol. I. 'Family Limitation and its influence on Fertility.'
„ III. 'Report of the Economics Committee.'
„ IV. 'Report of the Biological and Medical Committee.'
„ V. 'Memoranda.'

F. Zweig: *Labour, Life and Poverty.* Victor Gollancz Ltd., 1948.

P. E. P. 'Poverty Ten years after Beveridge' *Planning,* August 4, 1952.

Social Insurance and Assistance

Sir William Beveridge: *Report on Social Insurance and the Allied Services.* Cmd. 6404, 1942.

Family Allowances Act, 1945.

National Insurance (Industrial Injuries) Act 1946.

National Insurance Act, 1946.

National Insurance Act 1951.

Family Allowances and National Insurance Act, 1952.

National Insurance Act, 1946: First Interim Report by the Government Actuary for the period 5th July 1948 to 31st March 1950.

Report of the Ministry of National Insurance for the period 17th November 1944 to 4th July 1949, Cmd. 7955, and subsequent Reports.

National Assistance Act, 1948.
Annual Reports of the National Assistance Board.
Eleanor Rathbone: *Family Allowances*—a new edition of *The Disinherited Family*, with an epilogue by Lord Beveridge, and a new chapter on the Family Allowances Movement, 1924–47, by Eva M. Hubback. George Allen & Unwin, 1949.
William A. Robson: *Social Security*. George Allen & Unwin. First published 1943; revised third edition, 1948.
John D. Millett: *The Unemployment Assistance Board*. George Allen Unwin, Ltd., 1940.

The Health Services. General Development

W. M. Frazer: *A History of English Public Health, 1834–1939*. Ballière, Tindall & Cox, 1950.
Sir George Newman: *The Building of a Nation's Health*. MacMillan & Co., 1939.
J. L. Burn: *Recent Advances in Public Health*. J. & A. Churchill Ltd., 1947.
S. Leff: *The Health of the People*. Victor Gollancz, Ltd., 1950.
Ministry of Health: *On the State of Public Health during Six Years of War*. Report of the Chief Medical Officer of the Ministry of Health, 1939–45. H.M.S.O., 1946.

The National Health Service Act

Ministry of Health and Department of Health for Scotland: *A National Health Service*. Cmd. 6502, 1944.
Ministry of Health: *National Health Service Bill: Summary of the Proposed New Service*. Cmd. 6761.
National Health Service Act, 1946.
„ „ „ (Amendment) Act, 1949.
„ „ „ Act, 1951.
Ministry of Health: Circular 118/47, *National Health Service Act, 1946*. Health Services to be provided by Local Authorities under Part III of the Act.
Ministry of Health and Central Office of Information: *The National Health Service, 1948*.
Seventh Report from the Select Committee on Estimates, Session 1948–49: *The Administration of the Health Services*.
Eleventh Report from the Select Committee on Estimates, Session 1950–51: *Regional Hospital Boards and Hospital Management Committees*. H.M.S.O., 1951.
Central Health Services Council: Reports for the Periods ending December 1949 and December 1950 and subsequent reports,
P.E.P.: 'Medical Care for Citizens.' *Planning*, No. 222, June 1944.
'The Hospital Service.'
I. 'The System of Management.' *Planning*, Vol. XVI, No. 303, September 1949.

II. 'The Patient is Human.' *Planning*, Vol. XVI, No. 309, February 1950.

The Practitioner: 'The National Health Service Act in Great Britain, A Review of the First Year's Working, 1949.

Joseph S. Collings: 'General Practice in England To-day.' *The Lancet*, 25th March 1950.

Maternity and Child Welfare

G. F. McCleary: *Maternity and Child Welfare Movement.* P. S. King & Sons Ltd., 1935.

P.E.P.: 'A Complete Maternity Service.' *Planning*, No. 244, January 1946.

Joint Committee of the Royal College of Obstetricians and Gynaecologists and the Population Investigation Committee: *Maternity in Great Britain—A Survey of the Social and Economic Aspects of Pregnancy and Childbirth.* Oxford University Press, 1948.

Ministry of Health, Dept. of Health for Scotland, Ministry of Labour and National Service: Report of the Working Party on Midwives. H.M.S.O., 1949.

The Physically Handicapped

Report of the Inter-departmental Committee on the Rehabilitation and Resettlement of Disabled Persons. Cmd. 6415. H.M.S.O., 1943.

Ministry of Labour and National Service: Second Report of the Standing Committee on the Rehabilitation and Resettlement of Disabled Persons. H.M.S.O., 1949.

Ministry of Labour and National Service: Report of the Working Party on the Employment of Blind Persons. H.M.S.O., 1951.

British Medical Association: *Tuberculosis and the National Health Service.* 1950.

J. S. Clarke: *Disabled Citizens.* George Allen & Unwin Ltd., 1951.

Mental Health Services

Report of the Mental Deficiency Committee, being a Joint Committee of the Board of Education and the Board of Control. H.M.S.O., 1929. Reprinted 1931.

Part I. General.
„ II. The Mentally Defective Child.
„ III. The Adult Defective.
„ IV. Report on an Investigation into the Incidence of Mental Deficiency in Six Areas, 1925–7.

Report of the Royal Commission on Lunacy and Mental Disorders. Cmd. 2700, 1926.

Report of the Departmental Committee on Sterilisation. Cmd. 4485. H.M.S.O., 1934. Reprinted 1937.

Mental Deficiency Act, 1913.
„ „ „ 1927.

Lunacy Act, 1890.

Mental Treatment Act, 1930.
Ministry of Health: *National Health Service Act, 1946.* Provisions relating to the Mental Health Services. H.M.S.O., 1948.
Circular 100/47. *National Health Service Act, 1946.* Mental Health Services to be provided by Local Health Authorities. Formulation of Proposals for submission to the Minister.
Report of the Feversham Committee: *The Voluntary Mental Health Services.* 1939.
C. P. Blacker: *Neurosis and the Mental Health Services.* Oxford University Press, 1946.

Children and Young People

General

W. S. Craig: *Child and Adolescent Life in Health and Disease.* E. & S. Livingstone Ltd., 1946.
Alan Moncrieff and W. R. Thompson: *Child Health.* The Practitioner Handbooks. Eyre & Spottiswoode, 1947.
W. Clarke Hall and A. C. Morrison: *The Law relating to Children and Young Persons, including the Law of Adoption.* Butterworth & Co., 1951. First Supplement to Fourth Edition, 1953.

Education—Ancillary Services

G. A. N. Lowndes: *The Silent Social Revolution.* Oxford University Press, 1937.
Education Acts, 1944 and 1946: Education (Miscellaneous Provisions) Act, 1948.
Ministry of Education: *The Health of the School Child.* Report of the Chief Medical Officer of the Ministry of Education for the years 1939–45; 1946–47, and subsequent reports.
Handicapped Pupils and School Health Service. Regulations S.R. & O., 1945, No. 1076.
Circular 179. *The School Health Service and Handicapped Pupils—Effect of the Establishment of the National Health Service* August 1948.
Pamphlet No. 5. *Special Educational Treatment.* 1946.
Central Advisory Council for Education (England)
School and Life. 1947.
Out of School. 1948.
F. Le Gros Clark: *Social History of the School Meals Service.* National Council of Social Service, 1948.

Child Guidance and Mental Health

Burberry, Balint and Yapp: *An Introduction to Child Guidance.* Methuen & Co., 1945. Reprint, 1947.
National Association for Mental Health: *Occupation Centres for Mentally Defective Children.*
Finding Foster Homes, An Experiment. 1948.
Mental Health Aspects of Adoption.

Neglected and Deprived Children

Report of the Care of Children Committee: Presented by the Secretary of State for the Home Department, the Minister of Health and the Minister of Education to Parliament. Cmd. 6922, 1946.

Scottish Home Dept.: Report of the Committee on Homeless Children. Cmd. 6911, 1946.

Children Act, 1948.

Nursery and Child Minders Regulation Act, 1948.

Adoption Act, 1950.

Home Office, Ministry of Health: Memorandum on the Boarding-out of Children and Young Persons, 1946.

Reception Centres. Memorandum by the Home Office for Guidance of Local Authorities on the Provision of Accommodation for the Temporary Reception of Children under Section 15 (2) of the Children Act, 1948.

Home Office: Sixth Report on the Work of the Children's Department. May 1951.

Women's Group on Public Welfare: *The Neglected Child and His Family.* Oxford University Press, 1948.

Lena M. Jeger: *Illegitimate Children and their Parents.* National Council for the Unmarried Mother and her Child, 1951.

D. M. Dyson: *The Foster Home and the Boarded-out Child.* George Allen & Unwin Ltd., 1947.

J. Bowlby: *Maternal Care and Mental Health,* W.H.O., 1951.

Young People at Work and Leisure

Ministry of Labour and National Service: Report of the Committee on the Juvenile Employment Service, H.M.S.O., 1945.

Employment and Training Act, 1948.

Ministry of Labour and National Service: Central Youth Employment Executive. Report of the Youth Employment Council on the Work of the Youth Employment Service, 1947–50.

Central Youth Employment Executive. Youth Employment Service. Memorandum on the Exercise by Local Education Authorities in England and Wales and Education Authorities in Scotland of their Powers under Section 10 of the Employment and Training Act, 1948.

J. W. Reeves and V. W. Wilson: *Vocational Guidance in Warrington.* National Institute of Industrial Psychology.

H. Heginbotham: *The Youth Employment Service.* Methuen & Co. Ltd., 1951.

Ministry of Labour and National Service: *A Short Guide to the Factories Acts, 1937 and 1948.*

Home Office, Scottish Home Dept.: *Health, Welfare and Safety in Non-industrial Employments. Hours of Employment of Juveniles.* Report by a Committee of Enquiry. H.M.S.O., 1949, Cmd. 7664.

Annual Reports of the Chief Inspector of Factories.

Board of Education Circular 1486: *In the Service of Youth.* 1939.

P.E.P.: 'The Service of Youth To-day.' *Planning*, Vol. XV, No. 280, April 1948.

L. J. Barnes: *Youth Service in an English County*. Report prepared for King George's Jubilee Trust, 1945.

The Outlook for Youth Work. Ibid., 1948.

J. McAlister Brew: *In the Service of Youth*. Faber & Faber Ltd., 1943.

Informal Education. Faber & Faber Ltd., 1946.

Gordon Ette: *For Youth Only*. Faber & Faber Ltd, 1949.

Pearl Jephcott: *Girls Growing Up*. Faber & Faber, 1942.

P. I. Kitchin: *From Learning to Earning*. Faber & Faber, 1944.

Bryan H. Reed: *Eighty Thousand Adolescents*. A Study of Young People in the City of Birmingham. George Allen & Unwin, 1950.

The Welfare of Old People

Nuffield Foundation: *Old People*. Report of a Survey Committee on the Problems of Ageing and the Care of Old People. O.U.P., 1947.

Skill and Age. An Experimental Approach. O.U.P., 1951.

J. H. Sheldon: *The Social Medicine of Old Age*. Report of an Inquiry in Wolverhampton. Published for the Nuffield Foundation by the O.U.P., 1948.

Lord Amulree: *Adding Life to Years*. National Council of Social Service, 1951.

British Medical Association: *The Care and Treatment of the Elderly and Infirm*. 1949.

The Right Patient in the Right Bed. Supplement to the above.

Reports of the Nuffield Foundation and of the National Corporation for the Care of Old People.

Housing and Town and Country Planning

M. A. Bowley: *Housing and the State, 1919–44*. George Allen & Unwin, 1945.

M. Elsas: *Housing and the Family*. Meridian Press, 1947.

Ministry of Health: *Design of Dwellings*. H.M.S.O., 1944.

Management of Municipal Housing Estates. H.M.S.O., 1945. Reprint, 1949.

The Appearance of Housing Estates. H.M.S.O., 1948.

Selection of Tenants, Transfers and Exchanges. H.M.S.O., 1949.

Society of Women Housing Managers: *Rent Rebates. A Review*. 1950.

P.E.P.(Political and Economic Planning):

'Councils and their Tenants.' *Planning*, Vol. XIV, No. 282, May 1948.

'Housing Policy Abroad.' *Planning*, Vol. XVI, No. 299, June 1949.

'Rent Control Policy.' *Planning*, Vol. XVI, No. 305, November 1949.

'Economics of the Council House.' *Planning*, Vol. XVI, No. 308, January 1950.

'A New Policy for Housing Subsidies'. *Planning*, Vol. XVI, No. 312, April 1950.

'Town Planning and the Public.' *Planning*, Vol. XVI, No. 316, August 1950.

Report of the Royal Commission on the Distribution of the Industrial Population. Cmd. 6153, 1940.
Report of the Committee on Land Utilization in Rural Areas. Cmd. 6878, 1942.
M. P. Fogarty: *Town and Country Planning.* Hutchinson's University Library, 1948.
Lewis Mumford: *The Culture of Cities.* Secker & Warburg, 1940.
Patrick Geddes: *Cities in Evolution.* New and revised edition. Williams & Norgate, 1949.
Ebenezer Howard: *Garden Cities of To-morrow.* New edition with preface by F. J. Osborn. Faber & Faber, 1946.
L. E. White: *Community or Chaos. New Housing Estates and their Social Problems.* N.C.S.S., 1951.
New Towns, their Challenge and Opportunity. N.C.S.S., 1951.
Local and Regional Studies and Plans such as:
Ruth Glass: *The Social Background of a Plan. A Study of Middlesbrough.* Routledge & Kegan Paul, 1948; and
A. Minoprio and H. Spenceley: *An Outline Development Plan of the County and City of Worcester.* Prepared for the Reconstruction and Development Committee of the City Council, 1946.

Settlements and Community Centres

J. A. R. Pimlott: *Toynbee Hall. Fifty Years of Social Progress.* J. M. Dent & Sons Ltd., 1935.
Mary D. Stocks: *Fifty Years in Every Street; the Story of the Manchester University Settlement.* Manchester University Press, 1945.
Elizabeth Handasyde: *City or Community.* Report for the National Federation of Settlements of America. N.C.S.S., 1949.
National Council of Social Service: *Our Neighbourhood.* A Handbook of Information for Community Centres and Associations. 1950.
P.E.P.: 'Can Communities be Planned?' *Planning,* Vol. XV, No. 296, March 1949.
Ministry of Education: *Community Centres.* H.M.S.O., 1945.

Voluntary Organisations and Social Case Work

A. F. C. Bourdillon (ed.): *Voluntary Social Services. Their Place in the Modern State.* Methuen & Co., 1945.
Henry A. Mess and Others: *Voluntary Social Services since 1918.* Kegan Paul, Trench, Trubner & Co. Ltd., 1948.
Lord Beveridge: *Voluntary Action.* A Report on Methods of Social Advance. George Allen & Unwin, 1948.
The Evidence for Voluntary Action. Evidence of Organisations and Individuals. George Allen & Unwin, 1949.
National Council of Social Service: *Social Patterns,* being the Report of the British National Conference of Social Work, Harrogate, 1950.
Cherry Morris (ed.). *Social Case Work in Great Britain.* Faber, 1950.
Gordon Hamilton: *Theory and Practice of Social Case Work.* New York, 1940. New edition, revised, 1951.

Tom Stephens: *Problem Families*. First published 1945.
I. F. Beck: *The Almoner*. Institute of Almoners, 1948.
Elizabeth R. Glover: *Probation and Re-education*. Routledge & Kegan Paul, 1949.

Handbooks

Family Welfare Association: *Guide to the Social Services*. Published by the F.W.A., Denison House, Vauxhall Bridge Road, London, S.W.1, approximately annually.
John Moss: *Health and Welfare Services Handbook*. Hadden Best & Co. Ltd., Local Government publishers, 16 Strutton Ground, Victoria Street, London, S.W.1, 1948.
National Council of Social Service: *Public Social Services*. Handbook of Information on Services provided by the State. N.C.S.S., 26, Bedford Square, London, W.C.1, 1949.
Voluntary Social Services. A Handbook of Information and Directory of Organisations. 1949.
Citizens' Advice Notes. First published in loose-leaf form with special binder, subsequent additions and amendments issued periodically in supplements which can be incorporated in relevant sections.

Periodicals

Political and Economic Planning, 16, Queen Anne Gate, London, S.W.1: *Planning*. A fortnightly broadsheet.
National Council of Social Service: *Social Service*. A Quarterly Survey.
Family Welfare Association: *Social Work*. A Quarterly Review of Family Case Work.
Institute of Almoners, Tavistock House North, Tavistock Square, London, W.C.1: *The Almoner*. A Journal of Medical Social Work.
Association of Psychiatric Social Workers, 1 Park Crescent, London, W.1: *British Journal of Psychiatric Social Work*.
National Association for Mental Health, Maurice Cray House, 39, Queen Anne Street, London, W.1: *Mental Health*.
Institute of Public Administration, 76a, New Cavendish Street, London, W.1: *Public Administration*.
Society of Housing Managers, 13, Suffolk Street, London, S.W.1: *Quarterly Bulletin*.
Case Conference, a professional journal for the social worker and social administrator. 8 Codicote Road, Welwyn, Herts.

Supplementary List, 1951–4

Government Publications

Report of the Committee on the Economic and Financial Problems of the Provision for Old Age. Cmd. 9333, 1954.
National Insurance Act, 1946. Report by the Government Actuary on the First Quinquennial Review, 1954.

National Advisory Committee on the Employment of Older Men and Women. First Report. Cmd. 8963, 1953.
National Insurance, Retirement Pensions. *Reasons given for Retiring or Continuing at Work.* Report of an Enquiry by the Ministry of Pensions and National Insurance, 1954.
Sixth Report from the Select Committee on Estimates Session 1951–2. *Child Care.*
Home Office, Scottish Home Department. Report on the Departmental Committee on the Adoption of Children. Cmd. 9248, 1954.
Report of the Committee on the Law and Practice relating to Charitable Trusts. Cmd. 8710. 1952.
Fourth Report from the Select Committee on Estimates, Session 1951–2. *Training, Rehabilitation and Resettlement.*

Biography and History

Lord Beveridge: *Power and Influence.* Hodder & Stoughton, 1953.
S. E. Finer: *The Life and Times of Sir Edwin Chadwick.* Methuen & Co. Ltd., 1952.
M. B. Simey: *Charitable Effort in Liverpool in the Nineteenth Century.* University of Liverpool Press, 1952.
S. M. Ferguson and H. Fitzgerald: *Studies in the Social Services,* History of the Second World War, U.K. Civil Services. H.M.S.O., 1954.

The Health Services

J. S. Ross: *The National Health Service in Great Britain.* Oxford University Press, 1952.
C. Fraser Brockington: *The Health of the Community.* J. & A. Churchill Ltd., 1954.
Ffrangcon Roberts: *The Cost of Health.* Turnstile Press, 1952.
Thomas Ferguson and A. N. MacPhail. *Hospital & Community.* Nuffield Provincial Hospitals Trust. Oxford University Press, 1954.

Children and Young People

J. Spence, W. S. Walton, F. J. W. Miller, S. D. M. Court: *A Thousand Families in Newcastle-upon Tyne.* Nuffield Foundation and Nuffield Provincial Hospital Trust. Oxford University Press, 1954.
D. V. Donnison: *The Neglected Child and the Social Services.* Manchester University Press, 1954.
J. B. Mays: *Growing Up in the City.* University Press of Liverpool, 1954.
Hilda Lewis: *Deprived Children.* Nuffield Foundation. Oxford University Press, 1954.
M. Kornitzer: *Child Adoption in the Modern World.* Putnam, 1952.
Pearl Jephcott: *Some Young People.* George Allen & Unwin Ltd., 1954.

The Aged and the Handicapped

Over Seventy. Report of an Investigation into the Social and Economic Circumstances of One Hundred People over Seventy years of age. National Council of Social Service, 1954.

T. Ferguson, A. N. MacPhail and M. I. McVean: *Employment Problems of Disabled Youth In Glasgow.* Medical Research Council, Memorandum No. 28. H.M.S.O., 1952.

Housing, Town Planning and Community Organization

William Ashworth: *The Genesis of Modern British Town Planning.* Routledge & Kegan Paul Ltd., 1954.

H. Orlans: *Stevenage, a Sociological Study of a New Town.* Routledge & Kegan Paul Ltd., 1952.

L. Kuper (ed.): *Living in Towns.* Cresset Press, 1953.

Neighbourhood and Community. An inquiry into Social Relationships on Housing Estates in Liverpool and Sheffield. University Press of Liverpool, 1954.

J. M. Mackintosh: *Housing and Family Life.* Cassell & Co. Ltd., 1952.

Case Work

Winifred P. Smith & Helen A. Bate: *Family Case Work and Country Dweller.* Family Welfare Association, 1953.

Social Security

Ronald Mendelsohn: *Social Security in the British Commonwealth.* Athlone Press, 1954.

INDEX

Adolescents, 223–4, 229, 231
Adoption, 159, 160, 162–6
  Adoption Acts 1926–50, 162–5
  Report of Departmental Committee on, 166–167
'After-care'
  of Deprived Children, 201–2
  of Neglectful Mothers, 195
  of Tuberculous Persons, 78
  of Young Persons placed in Employment, 211
Agrarian Revolution, 4
Allen of Hurtwood, Lady, 197
Almoners, 113–15, 180, 210, 301
  Institute of Almoners, 112
Amsterdam, 139
Assistance
  National Assistance Act, 1948, 30, 42, 160 *n.* 240, 243, 245, 255, 308
  National Assistance Board, (formerly Assistance Board) 8, 42–7, 48, 81, 110, 124, 159, 191, 241, 242, 297
  Public Assistance Committees, 244
  Unemployment Assistance, 21, 27, 42, 43
Aycliffe, 97

Barlow, Sir Montague, 101
Barnardo, Dr., 147, 197
  Dr. Barnardo's Homes, 191
Barnes, L. J., 227
Barnett, Canon S., 107, 279, 280
Beavan, Margaret, 147
Bentham, Jeremy, 10
Bethlem Hospital, 267
Bevan, Aneurin, 61
Beveridge, Sir William, 18, 19, 28, 30, 39, 297
  Beveridge Report, 18, 23, 29, 30, 43, 47, 57, 288–9
Bevin, Ernest, 204
Birmingham, 84, 206, 227, 232
Blind, the, 251, 253–4, 255
  Blind Children, 177
  Blind Persons Acts 1920–38, 253–4
  National Institute for the Blind, 255, 256
  Working Party on the Employment of Blind Persons, 250
Booth, Charles, 10, 15, 16, 17
Bournville, 100
Bowley, Professor A. L., 17
Bradford, 52, 100, 172, 216
Brentwood Recuperative Centre, 193–4, 299
Brigades, 223, 227
Bristol, 19, 60, 96
British and Foreign Schools Society, 300
British Medical Association, 70
Brock, Dr. L. G., 263
Brockington, Dr. Fraser, 79
Brown, Miss Clement, 201
Burn, Dr. J. L., 177, 306
Burnett-Hurst, A. R., 17
Burt, Sir Cyril, 260

Case Work, 107–18, 122, 294 *n.*, 302
  Case Work Agencies, 123, 125, 138
  Case Work Principles, 107–10
  Case Workers, 109, 118, 127, 312
  Co-operation in Case Work, 112, 119, 289–92
  Family Case Work, 111–12, 119, 136
Catholic Marriage Advisory Council, 127, 130
Chadwick, Edwin, 5, 10, 50, 51, 52
Chapman, Dennis, 96
Charity, 6
Charity Organisation Society (later the Family Welfare Association), 16, 107–8, 110, 111, 132, 188, 189, 279, 281, 289, 298
Chesterfield, 111
Chicago, 185

Child Guidance, 11, 151
Child Guidance Clinics, 185–8
Child Life Protection, 58, 166–7, 199
Children
Care of Children Committee, (Curtis Committee), 162, 184, 197–8, 198, 201, 202, 289
Children Act, 1908, 6, 195
Children Act, 1948, 44, 63 *n.*, 198–9, 200, 202, 289 *n.*, 301
Children and Young Persons Act, 1933, 195–7
Children and Young Persons (Amendment) Act, 1952, 196
Children Deprived of Home Care, 197–202
Children 'in need of care or protection', 196
Children Neglected or Ill-treated in their Own Homes (Home Office Circular 157/50), 142, 192, 196–7, 291
Children's Allowances—see Family Allowances
Children's Committees, 198–9
Children's Officers, 196, 198, 199, 201, 202
Educationally Sub-normal Children, 181–3, 210
Handicapped Children, 177–89, 209–10, 253
Ineducable Children, 183–5, 264
Maladjusted Children, 185–8
National Society for the Prevention of Cruelty to Children, 195
Neglected Children, 191–6
Cholera, 51
Churches, 223, 228, 231
Church Assembly, 313
Citizens' Advice Bureaux, 58, 112, 119–123, 124, 125, 280, 294 *n.*, 297, 303
Citizens' Advice Notes, 120
Cohen, Dr. John, 66–7
Collings, Dr. J. S., 75
Community Centres and Associations, 216, 282–7
National Federation of Community Associations, 284, 296
Community Chests, 294–6
Compensation and Betterment, Expert Committee on, 101
Control, Board of, 261, 270–1, 273
Convalescent Care, 77
Co-operative Societies, 307 *n.*
Co-operative Youth Movement, 228
Cotton Factories Regulation Act, 1819, 213
County and County Borough Councils, 72, 78, 165, 192, 198, 252, 254
County Colleges, 227
County Districts, 72, 293
Courts
County Courts, 123, 162
Court of Appeal, 123
Courts of Summary Jurisdiction (Magistrates' Courts), 155, 160
High Court, 123, 162
Juvenile Courts, 162, 197
Cripples, 253
Central Association for the Care of Cripples, 255, 256
Customs and Excise, Department of, 28 *n.*

Damien, Father, 4
Darby and Joan Club, Streatham, 243
Deaf, the, 251, 252
National Institute for the Deaf, 255, 256
Death Grant, 6, 39
Delinquency, 9
Juvenile Delinquency, 8, 182, 225
Denning Committee—see Committee on Procedure in Matrimonial Causes
Development Corporations, 102
Dickens, Charles, 5
Disabled Persons, 248–56, 257
Disabled Persons (Employment) Act, 42, 209, 248–9, 250, 255
Disabled Persons Employment Corporation, 251
Disablement Benefit, 40
Disablement Resettlement Officers, 251, 257

Interdepartmental Committee on the Rehabilitation and Resettlement of Disabled Persons, 248
Dispensaries, 56
District Nursing Associations—see Nursing
Dudley, 84
Dundee, 151
Dyson, Miss D. M., 200

Edinburgh University, Department of Health and Social Medicine, 115
Education, 5, 148, 203
Board of Education, 169, 170, 225
Central Advisory Council for Education (England), 230
Education Act, 1921, 77, 182, 225, 259
Education Act, 1944, 55, 63 *n.*, 76, 171, 172, 179, 187, 189, 220, 221, 226, 259, 264, 284
Education (Administrative Provions) Act, 1907, 54, 172
Education (Blind and Deaf Children) Act, 1893, 178
Education (Choice of Employment) Act, 1910, 203
Education (Defective and Epileptic Children) Act, 1899, 178, 183
Education (Provision of Meals) Act, 1906, 54, 168, 172
Local Education Authorities, 55, 62, 154, 168, 169, 170, 171, 175, 180, 181, 187, 196, 203, 205, 208, 226, 229, 265, 303
Minister of Education, 6, 55, 174, 180, 208
Ministry of Education, 174, 187, 192, 205, 225, 227, 231, 284, 285, 286 *n.*
'Eighteen-Plus' Groups, 231
Emergency Medical Service, 61
Employment and Training Act, 1948, 204, 206, 208
Employment Exchanges (formerly Labour Exchanges), 5, 132, 205
Eugenics Society, 134
Evacuation, 133, 270
Evans, J. D., 252, 253

Factories
Factories Act, 1833, 214, 219
Factory Act, 1901, 214
Factories Act, 1937, 153, 214, 215–220, 221
Factories Act, 1948, 214, 219, 220
Factory Department, 216, 217
Factory Doctors, 219, 220
H.M. Inspectors of Factories, 214, 302 *n.*
Welfare Work in Factories, 216–17
Family Allowances, 19–25, 148, 156, 300
Family Allowances Act, 1945, 21–3, 29
Family Allowances and National Insurance Act, 1952, 21
Family Case Work—see Case Work
Family Discussion Bureaux, 127–8, 142, 275, 299
Family Limitation, 20, 83
Family Responsibility, 148, 309–11
Family Service Units, 136–8, 194, 299
Family Welfare Association (formerly Charity Organisation Society), 127, 130
Farr, William, 52
Feeble-minded, Royal Commission on the Care and Control of the, 259
Flats, 90
Fogarty, M. P., 97
Friendly Societies, 26, 77, 307 *n.*

Garden Cities, 100–1
Gaskell, Mrs., 5
General Practitioners, 56, 57, 68–70, 75, 111, 115
General Practitioner Obstetricians, 73
Geriatric Units, 59
Girl Guides, 224, 228
Greenwood, Arthur, 29
Guardians *ad litem*, 163, 164 *n.*, 165
Guardians, Boards of, 59, 60, 244

Halliday, Dr. James, 150, 151
Hamilton, Gordon, 107
Handasyde, Miss Elizabeth, 295

Handicapped Children—see Children
Harris, Dr. F. Drew, 52, 147
Harris Committee—see Marriage Guidance
Healy, William, 185
Health
  Boards of Health, 51
  Health Centres, 70–1
  Health Insurance—see Insurance
  Industrial Health, 162, 215
  Local Health Authorities, 55, 60, 68, 70, 72, 73, 75, 76, 77, 78, 149, 154, 155, 183, 264, 265, 27–72
  Medical Officers of Health, 51, 52, 54, 197
  Minister of Health, 63, 71, 255, 263
  Ministry of Health, 28, 52, 65, 68, 69, 80, 113, 121, 150, 152, 154, 155, 159, 161 *n.*, 174, 192, 242, 244, 255, 263, 264, 271, 272, 293, 302
  National Health Service Act, 1946, 34, 36, 50, 54, 61, 62–81, 113, 114, 129, 149, 150, 174, 187, 189, 256
  National Health Service Act, 1951, 44, 69, 81
  Public Health Act, 1848, 50
  Public Health Act, 1875, 52
  Public Health Act, 1936, 153
Hill, Octavia, 91, 92, 107
Holtby, Winifred, 308
Home Helps, 76
Home Office, 112, 191, 194, 198, 200, 217, 221, 225 *n.*
Home Secretary, 130, 217
Hospitals, 58–61, 64–7, 113
  General Hospitals, 59
  Hospital Management Committees, 64, 65, 67, 113, 295
  Municipal Hospitals, 59–60
  Regional Hospital Boards, 63, 64, 65, 72, 77, 78, 174, 187, 188, 189, 245, 266, 271
  Teaching Hospitals, 64
  Voluntary Hospitals, 59–60
Hours of Work of Women and Young Persons, 218, 221–2
Housing, 81–104, 173, 229 *n.*, 240–1
  Housing Act, 1930, 196
  Housing Act, 1935, 83
  Housing Act, 1936, 284
  Housing Act, 1949, 87
  Housing Costs, 89–90
  Housing Estates, 88, 94, 282
  Housing Management, 84, 85, 91–4
  Housing Policy, 82, 85
  Housing Repairs, 103
  Housing Repairs and Rents Act, 1954, 103
  Housing, Selection of Tenants, 94
  Housing Standards, 90
  Housing Subsidies, 86–8
  Institute of Housing, 85
Howard, Ebenezer, 100
Howard League for Penal Reform, 302
Huddersfield, 300

Idiots Act, 1886, 258
Ince, Sir Godfrey H., 204
Industrial Revolution, 4, 5, 50, 100, 213, 307
Insurance, 6, 8, 20, 26–42, 48, 132
  Ministry of National Insurance, 22, 29, 40, 42, 43
  National Health Insurance, 26, 27, 28 *n.*, 56–7, 80
  National Insurance Act, 1946, 23, 29, 31–9, 48, 153, 240
  National Insurance Act, 1951, 41, 48
  National Insurance Act, 1953, 33, 34
  National Insurance Act, 1954, 33, 35, 39
  Unemployment Insurance, 26, 27, 202
Invalid Children's Aid Association, 188–9, 280

Jewish Health Organisation, 186
Joint Boards, 72
Joint Consultation, 218
Jones, Agnes, 59 *n.*
Justices of the Peace (Magistrates), 5, 195, 214

Juvenile Employment Service (see also Youth Employment Service), 203–5
Committee on the Juvenile Employment Service (Ince Committee), 204, 208
Juvenile Organisations Committee, 225

Kay-Shuttleworth, Sir James, 5, 148, 300
Kerr, Dr. James, 52
Kershaw, Dr. J. D., 181
King Edward's Hospital Trust, 60, 246
King George's Jubilee Trust, 227

Labour
Labour Exchanges—see Employment Exchanges
Minister of Labour, 205, 206, 208
Ministry of Labour, 154, 203, 204, 205, 217, 250, 297
Laissez-faire, 5, 305
Lancaster, Joseph, 5, 299
Land Utilisation in Rural Areas, Committee on (Scott Committee), 101
Law Society, 123, 124
Legal Aid and Advice, 123–5
Legal Aid and Advice Act, 1949, 123–4
Legitimacy Act, 1926, 160
Leicester, 182
Letchworth, 101, 313
Lewis, Dr. E. O., 259, 261
Liverpool, 19, 51 *n.*, 59 *n.*, 60, 91, 134, 173, 300
Liverpool Child Welfare Association, 189
Lloyd-George, David, 26, 56
Local Authorities, 6, 54, 71, 78, 89, 95, 159, 172, 189, 193, 201, 241, 243, 244, 245, 251, 252 *n.*, 284, 292, 300, 303
Local Authority Information Centres, 120
Local Education Authorities—see Education
Local Health Authorities—see Health
Local Executive Councils, 68, 72, 73
Local Government Act, 1948, 121
Local Government Board, 52, 53
Loch, Charles, 107
London, 16, 19, 91, 101, 113, 128, 175, 178, 183, 213, 240, 280, 286
Life and Labour of the People of London, 10, 15
Lunacy—see Mental Illness
Lunacy Acts, 1845 and 1890, 267, 268
Lunacy Code, 271
Lunacy Commissioners, 267

McMillan, Margaret, 172
Magistrates—see Justices of the Peace
Magistrates' Courts—see Courts of Summary Jurisdiction
Mallon, J. J., 281
Manchester, 101, 134, 154 *n.*, 246
Manchester and Salford Ladies' Sanitary Reform Association, 52, 299
Manchester Family Welfare Service, 128
Manchester University Settlement, 90 *n.*, 281
Mannheim, Karl, 11
Marriage
Breakdowns, 8, 125
Departmental Committee on Grants for the Development of Marriage Guidance (Harris Committee), 9, 130, 302
Guidance, 126–30
Matrimonial Causes, Committee on Procedure in (Denning Committee), 9, 129, 302
Married Women
In Employment, 151–6, 170, 174
Position under the National Insurance Act, 31
Marshall, Professor T. H., 308
Maternal Mortality, 152
Maternity and Child Welfare
Maternity and Child Welfare Act, 1918, 53–4, 154

Maternity and Child Welfare Services, 53–4, 72–6, 149–51, 272, 311
Maternity in Great Britain—Report of a Survey Committee, 149, 151, 152, 153
Maternity Benefit, 23, 26, 27, 33–4, 153
Mead, Margaret, 82
Medical Officers of Health—see Health
Medical Practices Committees, 68–9
Medical Register, 56
Mental Deficiency, 257–66, 267
Interdepartmental Committee on Mental Deficiency (Wood Committee), 133, 182, 184, 258–9
Mental Deficiency Acts, 1913 and 1927, 258, 259, 264, 265 *n.*, 270
Mental Health Services, 63, 257–75
National Association for Mental Health, 185, 272
Mental Illness, 257, 263, 266–70
Mental Treatment Act, 1930, 268–269, 270, 271
Middlesbrough, 84
Midwives, 58, 72, 73, 74
Midwives Act, 1902, 53
Working Party on Midwives, 74
Milk Act, 1934, 170
Minn, W. G., 116
Moral Welfare, 158, 159, 160
Mutual Registration, 289–90

National Assistance Act—see Assistance
National Council of Social Service—see Social Service
National Health Service Act—see Health
National Insurance Act—see Insurance
Neighbourhood Units, 97, 98–9, 285
Netherlands, 139
New Towns Act, 1947, 102
Newman, Sir George, 148, 300
Newsholme, Sir Arthur, 53, 148, 300
Nightingale, Florence, 52
'Nightingale' Nurses, 59
Notification of Births, 54
Nuffield Foundation, 238, 240, 247
Nurseries, 154–5, 161, 210, 310
Nurseries and Child Minders Regulation Act, 1948, 155
Nursery Schools, 148, 167
Nurses
District Nurses, 58
District Nursing Associations, 53, 58, 76
Nurses Act, 1949, 67
Queen's Institute of District Nursing, 58
Working Party on the Recruitment and Training of Nurses, 66–7

Occupation Centres, 184–5, 265, 272
Old Age Pensions—see Pensions
Old People, 27, 237–47, 254, 307
Clubs for, 242–3
Employment of, 37–9, 237–8
Hostels for, 244–5
Housing of, 83, 240–1
Loneliness among, 242
Meals for, 243
National Corporation for the Care of Old People, 246–7
National Old People's Welfare Committee, 246–7, 292
Short-stay Homes for Old People, 239
Sickness and Infirmity among Old People, 245–6
Visiting of Old People, 242, 302
Oldham, 240
'Out of School' Committees, 230
Overcrowding, 10, 83–5, 95
Overseers of the Poor, 5
Owen, Robert, 100, 215

Pacifist Service Units, 136, 137
Papworth Village Settlement, 251
Parent-Teacher Associations, 186, 230
Parliament, 43, 45, 63, 214
Passmore Edwards Settlement, 178
Pensions
Old Age, 5, 27, 28 *n.*, 37–9, 80, 239, 240, 300
Widows' 34–6

Personnel Management, 212, 217
Physical Deterioration, Report of the Departmental Committee on, 54
Physical Training and Recreation Act, 1937, 284
Piercy, Lord, 208
Play Centres, 239, 280
Play Therapists, 186
Plymouth, 19, 194
Poor Law, 5, 6, 16, 27, 28, 42, 52, 60, 108, 168, 169, 254, 268, 297–8
  Poor Law Act, 1601, 5, 27
  Poor Law (Amendment) Act, 1834, 5 *n.*
  Poor Law Commissioners, 10
  Poor Law Infirmaries, 59
  Poor Law Medical Service, 55
  Royal Commission on the Poor Law, 59, 298
Poor Man's Lawyer Service, 112, 125, 280
Population, Royal Commission on, 23, 237, 310
Port Sunlight, 100
Poverty, 8, 10, 15–19, 28
  Poverty, a Study in Town Life, 10, 15
Probation, 116–17
  Probation Officers, 126, 299, 312
  Probation of Offenders Act, 1908, 6
Problem Families, 49, 96, 132–43, 157, 192, 291, 312
Psychiatric Social Work, 110, 117
  Psychiatric Social Workers, 185, 186, 274, 312
Public Assistance, 27

Queen Elizabeth's Training College, Leatherhead, 250
Queen's Institute of District Nursing—see Nurses
Querido, Dr., 139

Radford, Professor A. 3 *n.*, 8
Rainborough, Colonel T., 306
Ranger Home Emergency Service, 226
Rathbone, Eleanor, 19, 246, 300
Rathbone, William, 58, 59 *n.*
Recuperation Centres, 193–4
Red Cross, 242
Reed, Bryan H., 224, 227
Reilly, Sir Charles, 97
Remploy Factories, 210, 251
Rents, 85–8
  Rent Rebates, 88–9
Rhondda, 240
Robson, Professor W. A., 7
Rowntree, B. Seebohm, 10, 15, 48
Royal Free Hospital, 113
Rural Community Councils, 293, 296

St. Bartholomew's Hospital, 59
St. Helens 52, 147, 300
St. Loyes' College, 250
St. Thomas' Hospital, 59
Salford, 306
Salt, Titus, 100, 216
Salvation Army, 194
Sanitary Conditions of the Labouring Population, Report on, 10, 50
Sanitary Inspectors, 132
Satellite Towns, 101
School
  Attendance and Welfare Officers, 132, 179
  Care Committees, 175
  Health Service, 5, 54–5, 148, 171–5
  Managers, 297
  Meals, 25, 54, 148, 168–71, 310
  Medical Officers, 180
  Nurses, 174
  Special Schools, 178–81, 182, 183, 188, 264
Schweitzer, Albert, 4, 314
Scotland, 197
  Secretary of State for, 208
Scottish Committee on Homeless Children (Clyde Committee), 198 *n.*
Scottish Education Department, 205
Scottish Home Department, 221
Scouts, 224, 228
Settlements, 279–82, 283, 286–7
Shaftesbury, the Earl of, 214, 315
Sheldon, Dr. J. H., 237, 239, 241
Shops Act, 1934, 220
Sickness Benefit, 26, 36
Simon, Sir John, 51

Social Service
  Local Councils of, 292–4, 296
  National Council of, 286, 292–6
Social Services, 4–11, 107, 308
Social Surveys, 10
Social Workers, 3, 10, 291
  Recruitment and Training, 9, 112, 118
  Status, 290–1
Sons of Rest, 243
Soulbury, Lord, 8
South Shields, 57
Southampton, 19
Southwood-Smith, Dr., 5, 50
Speke, 101
Stallybrass, Dr., 134
State, the, 5, 7, 9, 30, 129, 192, 213, 222, 225, 226, 303, 309
  Welfare State, 6, 15, 22, 303, 305, 312
Stephens, T., 134, 138
Sterilisation, Departmental Committee on (Brock Committee), 260–262, 263
Stevenson, Professor A. C., 134
Stewart, Miss Mary, 113

Tavistock Institute of Human Relations, 10
Taylor, A. J. P., 305
Ten Hours Bill, 214
Tenants Associations, 93, 283
Titmuss, Professor R. M., 6
Toc H, 242
Town Planning, 100–2
Townsend, William, 313
Toynbee Hall, 280, 281
Trade Boards, 300
  Trade Boards Act, 1909, 132 *n.*
Trade Unions, 26, 282
Tredgold, Dr. A. F., 257
Tuberculosis, 76, 77–9, 251, 261, 272
  Tuberculosis Act, 1921, 78
  Tuberculosis Care Committees, 78
  Tuberculosis Dispensaries, 78, 108
Tuke, William, 267

Unemployment
  Assistance—see Assistance
  Insurance—see Insurance
  Welfare of Unemployed Persons, 296–7
Unmarried Mothers, 156–62, 302
  National Council for the Unmarried Mother and her Child, 158, 302

Verminous Infestation, 173–4
Vocational Guidance, 203, 205–6, 207, 210, 211
Voluntary Organisations, 8–9, 77, 128, 178, 188, 201, 223, 224, 226, 227, 228, 230, 241, 244, 254, 255, 272, 297–304
Volunteer Workers, 9, 122, 242, 297

Wages, 17
  Wages Councils—see Trade Boards
  'Wages Stop', 20–1
Ward, Mrs. Humphrey, 230
Warrington, 206
Waugh, Benjamin, 195, 315
Webb, Beatrice and Sidney, 297, 301
Welwyn Garden City, 101
Whitechapel, 279
Widows' Pensions—see Pensions
Williams, Mrs. Gertrude, 3
Williams, Norman, 96
Wolfe, Lawrence, 97
Wolverhampton, 237, 239
Women's Group on Public Welfare, 141, 191
Workmen's Compensation, 27, 40, 41
World Wars
  First, 52, 53, 86, 139, 225
  Second, 6, 18, 28, 86, 119, 121, 125, 140, 154, 159, 187, 217, 225–6, 270, 314
Wythenshawe, 101

York, 10, 15, 17, 19
Young Persons (Employment) Act, 1938, 220
Younghusband, Eileen, 175
Youth Employment Service, 203–11, 229

Central Youth Employment Executive, 204, 212
National Youth Employment Council, 208
Youth Employment Bureaux, 207, 208
Youth Employment Officers, 207–208, 211, 212
Youth Service, 223–33, 301
Youth Advisory Council, 225
Youth Clubs, 224, 228–9, 231, 232, 233, 280
Youth Committees, 225, 230
Youth Leaders, 231–2
Youth Organisations, 228, 304
Youth Organisers, 225

Founded by KARL MANNHEIM

Late Professor of Education in the University of London

Edited by W. J. H. SPROTT

Professor of Philosophy in the University of Nottingham

The International Library of Sociology and Social Reconstruction



ROUTLEDGE & KEGAN PAUL

BROADWAY HOUSE, CARTER LANE, LONDON, E.C.4

SOCIOLOGY OF EDUCATION

Mission of the University

JOSÉ ORTEGA Y GASSET. Translated and introduced by Howard Lee Nostrand *Second Impression.* 12*s.* 6*d.*

Total Education

A Plea for Synthesis

M. L. JACKS, *Director of the Institute of Education, Oxford*

Third Impression. 15*s.*

Education in Transition

A Sociological Analysis of the Impact of the War on English Education

H. C. DENT, *Late Editor of the "Times Educational Supplement"*

Fifth Impression. 14*s.*

The Social Psychology of Education

An Introduction and Guide to its Study

C. M. FLEMING, *Reader in Education, Institute of Education, London*

Eighth Impression. 9*s.* 6*d.*

Education and Society in Modern Germany

R. H. SAMUEL, *Professor of Germanic Languages, Melbourne,* and R. HINTON THOMAS, *Lecturer in German, Birmingham* 14*s.*

The Museum

Its History and Its Tasks in Education

ALMA S. WITTLIN *Illustrated.* 25*s.*

The Educational Thought and Influence of Matthew Arnold

W. F. CONNELL, *Senior Lecturer in Education, Sydney.* With an Introduction by Sir Fred Clarke 21*s.*

Comparative Education

A Study of Educational Factors and Traditions

NICHOLAS HANS, *Reader in Education, Institute of Education, London*

Fourth Impression. 21*s.*

New Trends in Education in the 18th Century

NICHOLAS HANS — 18*s.*

From School to University

A Study, with special reference to University Entrance

R. R. DALE, *Lecturer in Education, University College, Swansea* — 21*s.*

Education and Society

An Introduction to the Sociology of Education

A. K. C. OTTAWAY, *Lecturer in Education, Leeds.* With an Introduction by W. O. Lester Smith — *Second Impression.* 18*s.*

German Youth: Bond or Free

HOWARD BECKER, *Associate Professor in Primary Education, Akron* — 18*s.*

Parity and Prestige in English Secondary Education

OLIVE BANKS, *Lecturer in Sociology, Liverpool* — *In preparation*

Helvetius

His Life and Place in the History of Educational Thought

IAN CUMMING, *Senior Lecturer in Education, Auckland University College* — 25*s.*

SOCIOLOGY OF RELIGION

Sociology of Religion

JOACHIM WACH, *Professor of the History of Religions, Chicago* — 30*s.*

The Economic Order and Religion

FRANK KNIGHT, *Professor of Social Science, Chicago,* and THORNTON W. MERRIAM — 16*s.*

SOCIOLOGY OF ART AND LITERATURE

Chekhov and His Russia: A Sociological Study

W. H. BRUFORD, *Schröder Professor of German, Cambridge* 16*s.*

The Sociology of Literary Taste

LEVIN L. SCHÜCKING *Third Impression.* 8*s* 6*d.*

Men of Letters and the English Public in the 18th Century, 1660-1744, Dryden, Addison, Pope

ALEXANDRE BELJAME, Edited with an Introduction and Notes by Bonamy Dobrée. Translated by E. O. Lorimer 25*s.*

SOCIOLOGICAL APPROACH TO THE STUDY OF HISTORY

The Aftermath of the Napoleonic Wars

The Concert of Europe—An Experiment

H. G. SCHENK, *Lecturer in Political Economics, Fellow of Exeter College, Oxford* *Illustrated.* 16*s.*

Military Organization and Society

STANISLAW ANDRZEJEWSKI, *Simon Fellow, Manchester.* Foreword by A. Radcliffe-Brown 21*s.*

Lunacy, Law and Conscience, 1744-1845

The Social History of the Care of the Insane

KATHLEEN JONES, *Lecturer in Social Administration, Manchester* 21*s.*

SOCIOLOGY OF LAW

Sociology of Law

GEORGES GURVITCH, *Professor of Sociology, Sorbonne.* With an Intrduction by Roscoe Pound 21*s.*

The Institutions of Private Law and their Social Functions
KARL RENNER. Edited with an Introduction and Notes by O. Kahn-Freund 25*s.*

Legal Aid
ROBERT EGERTON. With an Introduction by D. L. Goodhart
Second Impression. 12*s.* 6*d.*

Soviet Legal Theory: Its Social Background and Development
RUDOLF SCHLESINGER, *Lecturer in Soviet Social and Economic Institutions, Glasgow* *Second Edition.* 25*s.*

CRIMINOLOGY AND THE SOCIAL SERVICES

Juvenile Delinquency in an English Middletown
HERMANN MANNHEIM, *Reader in Criminology, London School of Economics* 12*s.* 6*d.*

Criminal Justice and Social Reconstruction
HERMANN MANNHEIM *Second Impression.* 18*s.*

Group Problems in Crime and Punishment
HERMANN MANNHEIM *In preparation*

The Psycho-Analytical Approach to Juvenile Delinquency: Theory, Case Studies, Treatment
KATE FRIEDLANDER, *Late Hon. Psychiatrist, Institute for the Scientific Treatment of Delinquency* *Fourth Impression.* 21*s.*

The English Prison and Borstal Systems
LIONEL FOX, K.C.B., M.C., *Chairman of the Prison Commission for England and Wales* 30*s.*

Social Service and Mental Health
An Essay on Psychiatric Social Workers
M. ASHDOWN and S. C. BROWN 16*s.*

The Social Services of Modern England

M. PENELOPE HALL, *Lecturer in Social Science, Liverpool*

Third Edition (Revised). 25*s.*

Crime and the Services

JOHN SPENCER, *Director of the British Social Project, Bristol University*

28*s.*

SOCIOLOGY AND POLITICS

Social-Economic Movements

An Historical and Comparative Survey of Socialism, Communism, Co-operation, Utopianism; and Other Systems of Reform and Reconstruction

H. W. LAIDLER, *Executive Director, League for Industrial Democracy*

Second Impression. Illustrated. 35*s.*

The Analysis of Political Behaviour: An Empirical Approach

HAROLD D. LASSWELL, *Professor of Law, Yale. Third Impression.* 21*s.*

Dictatorship and Political Police

The Technique of Control by Fear

E. K. BRAMSTEDT 18*s.*

Nationality in History and Politics

A Psychology and Sociology of National Sentiment and Nationalism

FRIEDRICK HERTZ *Third Impression.* 28*s.*

The Logic of Liberty: Reflections and Rejoinders

MICHAEL POLANYI, F.R.S., *Professor of Social Studies, Manchester*

15*s.*

Power and Society

A Framework for Political Inquiry

HAROLD D. LASSWELL, *Professor of Law, Yale*, and A. KAPLAN, *Professor of Liberal Studies, Indiana* 23*s*.

The Political Element in the Development of Economic Theory

GUNNAR MYRDAL, *Professor of Economics, Stockholm, Executive Secretary, United Nations Economic Commission for Europe*. Translated from the German by Paul Streeten 25*s*.

FOREIGN AFFAIRS, THEIR SOCIAL, POLITICAL AND ECONOMIC FOUNDATIONS

Patterns of Peacemaking

DAVID THOMSON, *Research Fellow, Sidney Sussex College, Cambridge*, E. MEYER and ASA BRIGGS, *Fellow of Worcester College, Oxford* 21*s*.

French Canada in Transition

EVERETT C. HUGHES, *Professor of Sociology, Chicago* 15*s*.

State and Economics in the Middle East

A Society in Transition

A. BONNÉ, *Professor of Economics. Director, Economic Research Institute, Hebrew University, Jerusalem* *Second Edition (Revised)*. 40*s*.

Economic Development of the Middle East

An Outline of Planned Reconstruction

A. BONNÉ *Third Impression*. 15*s*.

The Danube Basin and the German Economic Sphere

ANTONIN BASCH 18*s*.

Peasant Renaissance in Yugoslavia, 1900-1950

A Study of the Development of Yugoslav Peasant Society as Affected by Education

RUTH TROUTON 28*s.*

Transitional Economic Systems

The Polish-Czech Example

DOROTHY W. DOUGLAS 25*s.*

The Regions of Germany

R. E. DICKINSON, *Professor of Geography, Syracuse*

Second Impression. 12*s.* 6*d.*

Political Thought in France from the Revolution to the Fourth Republic

J. P. MAYER 14*s.*

Central European Democracy and its Background

Economic and Political Group Organization

RUDOLF SCHLESINGER 30*s.*

ECONOMIC PLANNING

Private Corporations and their Control

A. B. LEVY. *Two volumes.* 70*s. the set*

The Shops of Britain

A Study of Retail Distribution

HERMANN LEVY *Second Impression.* 21*s.*

SOCIOLOGY OF THE FAMILY AND ALLIED TOPICS

The Family and Democratic Society

J. K. FOLSOM, *Professor of Economics, Vassar College* 30*s.*

Nation and Family

The Swedish Experiment in Democratic Family and Population Policy

ALVA MYRDAL, *Director of the Dept. of Social Sciences, UNESCO*

Second Impression. 25*s.*

Adolescence

Its Social Psychology: With an Introduction to recent findings from the fields of Anthropology, Physiology, Medicine, Psychometrics and Sociometry

C. M. FLEMING, *Reader in Education, Institute of Education, London*

Third Impression. 18*s.*

Studies in the Social Psychology of Adolescence

J. E. RICHARDSON, J. F. FORRESTER, J. K. SHUKLA and P. J. HIGGINBOTHAM

Edited by C. M. FLEMING 21*s.*

The Deprived and the Privileged

Personality Development in English Society

B. M. SPINLEY, *Educational Psychologist, Sheffield Child Guidance Clinic* 18*s.*

Prosperity and Parenthood

J. A. BANKS, *Assistant Lecturer in Sociology, Liverpool* 21*s.*

TOWN AND COUNTRY PLANNING. HUMAN ECOLOGY

The Social Background of a Plan: A Study of Middlesbrough

Edited by RUTH GLASS. With Maps and Plans 42*s.*

City, Region and Regionalism

A Geographical Contribution to Human Ecology

ROBERT E. DICKINSON. With Maps and Plans

Second Impression. 25*s.*

The West European City: A Study in Urban Geography

ROBERT E. DICKINSON. With Maps and Plans 42*s.*

Revolution of Environment

E. A. GUTKIND *Illustrated.* 30*s*

The Journey to Work

Its Significance for Industrial and Community Life

K. LIEPMANN, *Research Fellow in Economics, Bristol.* With a Foreword by Sir Alexander Carr-Saunders *Second Impression.* 15*s.*

Stevenage: A Sociological Study of a New Town

HAROLD ORLANS 30*s.*

The Genesis of Modern British Town Planning

A Study in Economic and Social History of the Nineteenth and Twentieth Centuries

W. ASHWORTH, *Lecturer in Economic History, London School of Economics*

21*s.*

SOCIOLOGICAL STUDIES OF MODERN COMMUNITIES

Negroes in Britain

A Study of Racial Relations in English Society

K. L. LITTLE, *Reader in Anthropology, Edinburgh* 25*s.*

Co-operative Living in Palestine

HENRIK F. INFIELD. With a Foreword by General Sir Arthur Wauchope *Illustrated.* 10*s. 6d.*

Co-operative Communities at Work

HENRIK F. INFIELD 18*s*

Colour Prejudice in Britain

A Study of West Indian Workers in Liverpool, 1941-1951

ANTHONY H. RICHMOND, *Lecturer in Social Theory, Edinburgh* 18*s.*

Social Mobility in Britain

Edited by DAVID V. GLASS, *Professor of Sociology, London School of Economics* 36*s.*

Mobility in the Labour Market

MARGOT JEFFERYS, *Lecturer, London School of Hygiene and Tropical Medicine* 15*s.*

The Absorption of Immigrants

S. N. EISENSTADT, *Head of the Department of Sociology, Hebrew University, Jerusalem* 25*s.*

Higher Civil Servants in Britain

From 1870 to the Present Day

R. K. KELSALL, *Senior Research Officer, London School of Economics* 25*s.*

Patterns of Industrial Bureauracy

ALVIN W. GOULDNER, *Professor of Sociology, Illinois* 21*s.*

Wildcat Strike

A Study of an Unofficial Strike

ALVIN W. GOULDNER 16*s.*

Studies in Class Structure

G. D. H. COLE, *Chichele Professor of Social and Political Theory, Oxford*

In preparation

ANTHROPOLOGY AND COLONIAL POLICY

The Sociology of Colonies: An Introduction to the Study of Race Contact

RENÉ MAUNIER, *Member of the French Academy of Colonial Sciences.* Translated from the French by E. O. Lorimer *Two volumes.* 63*s. the set*

A Chinese Village: Taitou, Shantung Province
MARTIN C. YANG 21*s.*

A Japanese Village: Suye Mura
JOHN F. EMBREE, *Associate Professor of Anthropology, California.* With an Introduction by A. R. Radcliffe-Brown *Illustrated.* 21*s.*

The Golden Wing: A Sociological Study of Chinese Familism
YUEH-HWA LIN, *Professor of Social Anthropology, Yenching.* Introduction by Raymond Firth 16*s.*

Earthbound China: A Study of Rural Economy in Yunnan
HSIAO-TUNG FEI, *Professor of Sociology, National Yunnan,* and CHIH-I CHANG, *Lecturer in Sociology, National Yunnan* *Illustrated.* 18*s.*

Under the Ancestors' Shadow: Chinese Culture and Personality
FRANCIS L. K. HSU, *Professor of Anthropology, College of Liberal Arts, North Western University* *Illustrated.* 21*s.*

The Mende of Sierra Leone
A West African People in Transition
K. L. LITTLE 28*s.*

Transformation Scene: The Changing Culture of a New Guinea Village
H. IAN HOGBIN, *Reader in Anthropology, Sydney* *Illustrated.* 30*s.*

Indians of the Andes: Aymaras and Quechuas
HAROLD OSBORNE *Illustrated.* 25*s.*

Religion, Science and Human Crises
A Study of China in Transition and Its Implications for the West
FRANCIS L. K. HSU 14*s.*

Colour and Culture in South Africa
A Study of the Status of the Cape Coloured People within the Social Structure of the Union of South Africa
SHEILA PATTERSON 30*s.*

The Family Herds

P. H. GULLIVER, *Government Sociologist, Tanganyika Illustrated.* 25*s.*

Growing Up in an Egyptian Village

HAMED AMMAR, *Lecturer in the Sociology of Education, Heliopolis University, Cairo* 28*s.*

Indian Village

S. C. DUBE, *Professor of Sociology, Osmania University, Hyderabad* 25*s.*

SOCIOLOGY AND PSYCHOLOGY OF THE PRESENT CRISIS

Diagnosis of Our Time

Wartime Essays of a Sociologist

KARL MANNHEIM *Sixth Impression.* 18*s.*

Farewell to European History or the Conquest of Nihilism

ALFRED WEBER 16*s.*

The Fear of Freedom

ERICH FROMM *Sixth Impression.* 21*s.*

Freedom, Power, and Democratic Planning

KARL MANNHEIM. Edited by Hans Gerth and E. K. Bramstedt 25*s.*

Essays on Sociology and Social Psychology

KARL MANNHEIM. Edited by Paul Kecskemeti 25*s.*

SOCIAL PSYCHOLOGY AND PSYCHO-ANALYSIS

Psychology and the Social Pattern

JULIAN BLACKBURN, *Associate Professor of Psychology, McGill University, Canada* *Fifth Impression.* 14*s.*

The Framework of Human Behaviour

JULIAN BLACKBURN *Second Impression.* 15*s.*

A Handbook of Social Psychology

KIMBALL YOUNG, *Professor of Sociology, Northwestern University*
Fifth Impression. 28*s.*

Solitude and Privacy

A Study of Social Isolation, Its Causes and Therapy

PAUL HALMOS, *Lecturer in Social Psychology, Social Studies Dept., South West Essex Technical College* 21*s.*

The Human Group

GEORGE C. HOMANS, *Associate Professor of Sociology, Harvard* 25*s.*

Sigmund Freud: An Introduction

A Presentation of his Theories and a Discussion of the Relationship between Psycho-analysis and Sociology

WALTER HOLLITSCHER, *Professor of Philosophy and Sociology, Humboldt University, Berlin* *Second Impression.* 10*s.* 6*d.*

The Social Problems of an Industrial Civilization

ELTON MAYO, *Late Professor of Industrial Research, Harvard Business School* *Second Impression.* 15*s.*

Oppression

A Study in Social and Criminal Psychology

TADEUSZ GRYGIER. Foreword by Hermann Mannheim 28*s.*

APPROACHES TO THE PROBLEM OF PERSONALITY

The Cultural Background of Personality

RALPH LINTON, *Professor of Anthropology, Yale*
Third Impression. 12*s.* 6*d.*

The Feminine Character: History of an Ideology

VIOLA KLEIN. With an Introduction by Karl Mannheim 14*s.*

A History of Autobiography in Antiquity

GEORG MISCH, *Professor of Philosophy, Göttingen.* Translated by E. W. Dickes. *Two volumes.* 42*s. the set*

Personality and Problems of Adjustment
KIMBALL YOUNG *Second Edition (Revised).* 35*s.*

PHILOSOPHICAL AND SOCIAL FOUNDATIONS OF THOUGHT

Homo Ludens: A Study of the Play Element in Culture
J. HUIZINGA 18*s.*

The Ideal Foundations of Economic Thought
Three Essays on the Philosophy of Economics
WERNER STARK, *Reader in Economics, Manchester*
Third Impression. 15*s.*

The History of Economics in its Relation to Social Development
WERNER STARK *Third Impression.* 10*s.* 6*d.*

America: Ideal and Reality
The United States of 1776 in Contemporary European Philosophy
WERNER STARK 10*s.* 6*d.*

The Decline of Liberalism as an Ideology
With Particular Reference to German Politico-Legal Thought
J. H. HALLOWELL 12*s.* 6*d.*

Society and Nature: A Sociological Inquiry
HANS KELSEN, *Department of Political Science, California* 25*s.*

Marx: His Time and Ours
R. SCHLESINGER *Second Impression.* 30*s.*

The Philosophy of Wilhelm Dilthey
H. A. HODGES, *Professor of Philosophy, Reading* 28*s*

Essays on the Sociology of Knowledge
KARL MANNHEIM 25*s.*

GENERAL SOCIOLOGY

A Handbook of Sociology

W. F. OGBURN, *Professor of Sociology, Chicago*, and
M. F. NIMKOFF, *Professor of Sociology, Bricknell*

Third Edition (*Revised*). 28*s*.

Social Organization

ROBERT H. LOWIE, *Professor of Anthropology, Chicago* 25*s*.

FOREIGN CLASSICS OF SOCIOLOGY

Wilhelm Dilthey: An Introduction

A comprehensive account of his sociological and philosophical work, with translations of selected passages.

H. A. HODGES *Second Impression.* 12*s*. 6*d*.

From Max Weber: Essays in Sociology

Translated, Edited, and with an Introduction by H. H. GERTH and C. W. MILLS *Second Impression.* 25*s*.

Suicide: A Study in Sociology

EMILE DURKHEIM. Translated by J. A. Spaulding and George Simpson 25*s*.

Community and Association

FERDINAND TONNIES. Edited and supplemented by Charles P. Loomis 21*s*.

DOCUMENTARY

Changing Attitudes in Soviet Russia

The Family in the U.S.S.R.

Documents and Readings. Edited with an Introduction
RUDOLF SCHLESINGER 28*s*.

The Nationality Problem in Soviet Administration

RUDOLF SCHLESINGER *In preparation*

All prices are net

28255 THE WESTMINSTER PRESS, LONDON W.9