Conversations on the Social Services

Psychiatric Aspects

FROM A SPECIAL CORRESPONDENT

Dr. K is a psychiatrist in the Greater London area. Towards the end of the conversation he was joined by Mr. L, a social worker from a drug dependency centre.

British Medical Journal, 1974, 3, 109-110

"I work in three places; one of them is a general mental hospital with 1,350 beds and a large psychogeriatric population—800 people over 65. We have been working with two authorities, and in one of them the mental services were provided by five very widely scattered hospitals, so if we worry about the social services, they have even more to worry about on the hospital side. The April reorganization should improve this somewhat, and ultimately we will be entirely in one district; and after that the social services department will find it much easier to plan with us, and we with them. Both our social service departments are co-operative, though one was more competent in mental welfare than the other. After Seebohm, as after any reorganization, people tended to move; the mental welfare department as we knew it disappeared; and for a time one had the problem of people who had nothing to do with mental health turning up and trying to act, and worrying about depriving people of their liberty. This is the sort of thing that one always gets after a re-shuffle, but I don't think there have been any great difficulties.

No Real Changes

"What is happening is that having gone away from the specialized social worker to the generic type, they are beginning to come back to specialization. I don't think that difficulties between doctors and social workers are any worse than they were, and the idea that once upon a time there was a host of happy social workers at the beck and call of doctors is a load of old rubbish. Now that we've had a couple of years, the dust is settling, and I can't say I've noticed any marked changes, and I must say I would be in favour of those that have come about.

"Resources are inadequate, of course, but so is everything in London, and I find it difficult to assess priorities. I think there are too many homes where people who have least need get places because they are quiet and amiable, and those who are slightly more disturbed can't find a place, and so are more likely to end up in a mental hospital. If more money was available, I would prefer to see it spent in the community. Certainly I think there should be more in the way of hostels and halfway houses for those with mental illness, not necessarily severe or acute, who with a lot of support could be kept in the community.

"Our social workers will now come under the social service department, but those in hospital will continue to work there. As these leave there will be more exchange. I think myself this will be advantageous; when it's working there will be good collaboration between services inside and outside hospital. What I think is that at district level we are beavering away together, but I don't now see how we are to get liaison at area level.

"Most of our medical social workers spend about a couple of years getting special experience here; they move on, and as part of experience it is desirable. It is important to let social workers have a say in management. Ours recently carried out a survey of every single patient—about 1,450—and made an individual assessment of whether it was likely, possible, or unlikely that each would be discharged. It would be very hard to do this if they were coming in on a job assignment basis, and doctors probably aren't as good as they are at assessing social needs.

Changing Face of Social Work

"There are more women than men among our social workers; that may be a reflection of the economic position, women are always low paid. Things are changing from the days of lady almoners. I worked in a hospital where the matron's secretary became the first lady almoner, and her secretary the second, and *her* secretary became the first social worker. Now the number of men is increasing, and their view of their role is changing. They feel they have to be more activist, and I don't see this as a bad thing.

"They have, of course, to find their role. I believe there is a very large amount of elementary welfare that could be done by an intelligent clerk. At the end of training the social workers are broad in outlook, but weak on some of the practical points, and, on the other hand, you have practical people without vision. You need a mixture; perhaps it would be better to have more social work aides. Sometimes you feel you refer people and nothing gets done, but is this perhaps because there is nothing one can do, and we tend to refer all the problems we can do nothing about?

"One area which hasn't been clear is their responsibility in their primary role. Child battering is a case in which they are on a hiding to nothing. When it comes to court, they are held to have got it wrong no matter what they did. The doctor may with the benefit of hindsight be proved wrong, but provided he has exercised due care he is all right. The social worker, even if he has taken the greatest care, is still liable to be blamed. The professional implications of this will have to be worked out."

Medical Social Worker's View

Mr. L—"There are a lot of activist social workers who feel

Br Med J: first published as 10.1136/bmj.3.5923.109 on 13 July 1974. Downloaded from http://www.bmj.com/ on 18 April 2024 by guest. Protected by copyright.

the whole system is bad and needs changing, but they tend either to leave, or to lose their fire, and I think this is a pity. You can identify with your clients without adopting their standards. I certainly wouldn't smoke pot; if you are known to be working with these problems and you smoked pot they would look on it as a breach of faith. I would like to see more crisis intervention. Police and casualty departments are big enough to give a real 24-hour service, but the duty social worker for a borough can only deal with real emergencies like suicide. It's very difficult to get a doctor, except a deputy, out of hours, but you've still got the hospital casualty department to fall back on. It takes a large number of people to provide a real 24-hour cover, and the social services haven't got round to this."

Dr. K.—"There aren't as many medical emergencies nowadays in this country because people come for treatment earlier. There used to be a lot of serious illness because people hung about before seeking treatment. Perhaps eventually the social services will get less crisis work because they are called in earlier."

Any Questions?

We publish below a selection of questions and answers of general interest

Health Hazards of Hamsters

What are the health hazards of children keeping pet hamsters in the house and what precautions should be taken if this is done?

As a species hamsters are relatively free of serious infectious diseases. This certainly applies to those kept under laboratory conditions but probably less so to hamsters purchased from pet shops where standards of hygiene may be low. Any health hazards from children keeping pet hamsters in the house can be reduced by taking the following precautions. When selecting a hamster as a pet avoid doubtful traders as purchasing any animal from such sources invariably results in also purchasing disease. Obtain the animal from a known reputable source and if there are doubts about its fitness it should be examined by a veterinary surgeon. Reasonable precautions within the family will eliminate many disease risks. Infections usually spread from the mouth, nose, skin, droppings, or urine of an animal to the mouth or skin of the owner. So do not let animals lick human mouths or play at kissing, and after handling an animal always wash the hands. Personal hygiene is especially important after cleaning cages, grooming, or contact with any droppings. The fact that both animals and humans may carry disease must be accepted; hygiene and common sense will reduce risks.

Notes and Comments

Best Age for Measles Vaccination.—Dr. J. YARNELL of Bristol writes: The reply to this question (6 April, p. 48) suggests that the preferred age for vaccination is three or over. In a follow up study conducted in Bristol,[1] 623 children were vaccinated against measles and 269 "controls" were selected from the unvaccinated child population. Age-specific reaction rates were calculated for all children aged between 10 and 63 months. In general, reactions observed by nurse/fieldworkers and by mothers decreased with age in both the vaccinated and unvaccinated groups of children. The overall conclusion drawn was that reactions were more likely to be reported by mothers of younger than older children. Other studies[2-4] have suggested that the febrile response after measles vaccination is of a comparable order in younger and older children. Because of these findings, therefore, and, as measles still occurs commonly in children under three, it appears premature to advocate routine immunization of children at three or older.

[1] Medical Research Division of the Health Education Council, *Age-specific reaction rates in children vaccinated with the Schwarz strain of live attenuated measles vaccine.* Unpublished.
[2] Miller, G., *et al., American Journal of Public Health*, 1967, **57,** 1333.
[3] Swartz, T., *et al., Bulletin of the World Health Organization*, 1968, **39,** 285.
[4] Martin du Pan, R., *Bulletin of the World Health Organization*, 1965, **32,** 331.

OUR EXPERT replies: The Bristol survey findings appear to confirm my view that the background incidence of reactions in young children decreases with age. Similar observations have been made in placebo groups in measles vaccine trials.[1] The studies referred to by Dr. Yarnell do not clearly support his contention that the febrile response after measles vaccination is of a comparable order in younger and older children. In the first study,[2] temperatures of $\geqslant$ 39·5°C were recorded in 17 of 42 vaccinated children between 12 and 23 months and 13 of 55 children over 24 months. In the second study,[3] a clear comparison is made only between vaccinated children of between 3 and 4 years of age. The percentage of children with temperatures of $\geqslant$ 38·3°C given on a histogram, cannot be reconciled with the small number of children in the $\geqslant$ 4 year-old group. Comparison of reactions based on the ages of the children is not apparent in the last paper.[4] A study[5] involving over a thousand persons of wide age range in a virgin population in Arctic Greenland showed that febrile response after measles vaccines decreased with the age of the subjects. Maximum reactions were in the youngest children from 8 to 12 months old. Trials involving nearly 1,000 children in Iran[1] showed that irrespective of vaccine strain or location reactions were consistently less severe in children over 2 than in children under that age. Though the numbers of children under and above 2 were similar, 12 of the 13 post-vaccination convulsions were in the younger group of children. In natural measles also the incidence and severity of complications decline as the age of the children increases.[6] I agree that it is premature to postpone *routine* measles vaccination until 3 years old while the risk of measles epidemics persists. Epidemics, however, could be avoided if a high proportion of measles-susceptible children between 3 and 5 were vaccinated.

[1] Naficy, K., *et al., Archiv für die gesamte Virusforschung*, 1967, **22,** 11.
[2] Miller, G., *et al., American Journal of Public Health*, 1967, **57,** 1333.
[3] Swartz, T., *et al., Bulletin of the World Health Organization*, 1968, **39,** 285.
[4] Martin du Pan, R., *Bulletin of the World Health Organization*, 1968, **32,** 331.
[5] Mordhorst, C. M., Tulinius, S., and Magnus, H. von, *Danish Medical Bulletin*, 1968, **15,** 263.
[6] Miller, D. L., *British Medical Journal*, 1964, **2,** 75.

Br Med J: first published as 10.1136/bmj.3.5923.109 on 13 July 1974. Downloaded from http://www.bmj.com/ on 18 April 2024 by guest. Protected by copyright.