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PRESCRIBING AND COMPOUNDING SERVICES

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Present Inadequate Utilisation of Services

Studies have shown that sources of social help are frequently not used when they might have been and sometimes are inefficiently and even ineffectively used. Follow-up studies of children with severe handicaps have shown that many have not received all the help they should have had, have not been prepared adequately for adult life, and that their families have been left without guidance (e.g. Ferguson and Kerr, 1960; British Council for Rehabilitation of the Disabled, 1963; Carnegie United Kingdom Trust, 1964). Brown and Carling (1945) found that 70% of 150 consecutive patients treated in a general medical ward in a teaching hospital required careful supervision after discharge if full use was to be made of existing social agencies so that recovery might be as rapid, comfortable and complete as possible. The majority did not get this supervision. Professor T. Ferguson and others have shown that relapse can often be attributed as much to bad social and environmental conditions and failure of after-care as to any inevitable progress of the pathological condition (e.g. Ferguson and MacPhail, 1954; M. McKenzie and colleagues, 1962; Querido, 1959; Donabedian and Rosenfeld, 1965). Community services for the elderly are often called in too late for remedial action (Geffen and Warren, 1954) and there is considerable evidence that even those needs of old people for which there are services are not being fully met (Townsend and Wedderburn, 1965).

Sociological research workers have recently drawn attention to the gulf between the present situation and the doctor's image of himself as the director and coordinator of services helping his patient (Ministry of Health, 1963; Ministry of Health, 1965). Rodgers and Dixon (1960) surveyed the social work being carried on in a small county borough in the North. They reported that the most striking fact was the "sketchiness of the doctors' knowledge of the social services. They have no experience of working with the staffs of the various departments and are often unaware that particular workers exist". Jefferys (1965) in her comprehensive study of the staff and clients of social welfare services in a county found that "while general practitioners were directly or indirectly helping about two-thirds of the patients with problems, they were only aware of help provided by other social welfare services in about two-fifths of the cases, and were only in touch with other services in under a third".

The responsibility for this tardy and deficient use of services is not the doctors' alone. The services, themselves, have been developed at different times, in different places, often in response to sudden social pressures. The result is that the services are confusing to describe and understand. Furthermore, many patients do not comply with the doctors' recommendations concerning the use of services. For example, Donabedian and Rosenfeld (*op. cit.*) found that about one half of a group of

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chronically ill patients discharged from hospital did not comply with the instructions they had been given. The reasons for non-compliance were that the patient doubted the value of the service recommended, did not understand the instruction given, did not understand the nature of his illness and therefore the need for the service, was apathetic or negligent or his family was uncooperative.

Medico-Social Diagnosis

The first step in using services is to make a medico-social diagnosis of the patient's total situation. There is a tendency to apply services before a full assessment has been made; this results in a categorization of problems, fragmentary utilisation of services and ineffective help. Often, in complex cases, it is necessary to seek the opinions of other workers concerned with the patient in order to define all the problems; medical people tend to see mainly medical problems and social workers mainly social problems. The diagnosis of the medico-social situation is made by a combination of the material obtained from the history of the patient, the results of examination and treatment, observations made of the patient's attitudes and responses to rehabilitation, his previous ability to cope with setbacks and stresses, and from data obtained from other sources such as information from other professions, documents, work records and relatives. Much of the data is subjective and therefore requires interpretation and evaluation. A medico-social study attempts to get as clear a picture as possible of the external reality situation and of the patient's personal view of it, so that the prescription for medico-social treatment can be adapted to the resources of the patient, of his family and of the community. In intricate cases, the diagnosis and treatment may best be decided upon at a case-conference (see below).

Needs of handicapped people have many common elements regardless of the nature of the disability or the age of the patient; although as is mentioned below with children and old people there are very important special factors that must be taken into account. The overriding need is for each handicapped person to live a life which is as nearly normal and as full of variety, interest and satisfaction as his disability permits. Each basic need of temporarily and permanently handicapped people should be systematically considered before a plan of treatment is made. The following list

of needs is suggested as an *aide-mémoire* for such a review: —

1. Full medical and/or surgical treatment

This is very obvious but is sometimes overlooked. A specialist may be unaware of a disorder in another system of the body; for example, an ophthalmologist may not know a patient has bilateral inguinal herniae. It is, therefore, necessary to carry out a full clinical examination with special reference to those systems of the body not involved in the primary disability. From time to time the treatment given to patients with chronic disease needs to be reviewed in the light of recent advances in treatment; perhaps some new drug will control the disease better (e.g. in epilepsy or Parkinsonism) or a new operation may offer help (e.g. in otosclerosis). It is a disaster to embark on extensive social help, if remedial treatment could have enabled the patient to do more for himself.

2. Psychological adjustment of the patient and his family

Whatever the illness or handicap, the patient has to learn to accept it, to live with it and so far as possible to overcome its effects. The family must also understand what the handicap means, the frustrations and stresses it produces in the patient, how much they should do to help and their own feelings towards the new situation. Too often, patients understand too little about their illness; doctors and nurses tell the patient less than he wants or needs to know and the patients have trouble understanding the little they are told (Cartwright, 1964). But it is not knowledge alone that one is concerned with, for knowledge does not necessarily result in the appropriate action. The patient's self-respect and confidence in the future must be restored. Careful, patient, supporting work over a period of weeks or months may be required to achieve this, before the patient will accept any other help.

3. Independence in self-care

This refers to ensuring that the patient can dress, feed and wash himself and manage his own toilet.

4. Adequate financial income

Has the patient an adequate income? If not, what resources can be mobilised? It is known, for example, that a large number of retirement

pensioners are not obtaining supplementary allowances to which they are entitled. Voluntary societies will often make grants to help out at times of crisis; or to meet an unexpected, additional expense.

5. *Accommodation*

Is the patient's housing suitable? If not, what adaptations are required? Must rehousing be considered? Would the patient's needs and desires be better met in residential accommodation (e.g. special school, residential unit for the severely handicapped which affords opportunities for occupation, recreation, companionship and nursing assistance, or a Home for elderly people)?

6. *Mobility in the home and outside*

How mobile is the patient? Can his range be increased by the use of walking-aids, calipers, wheel-chair, modified controls in a car? Can he use, or be trained to use public transport? The answers to these questions will influence decisions about occupation and recreation.

7. *Occupation*

The aim here is for the patient to be able to obtain or return to gainful employment or, in the case of the housewife, to carry out her multitudinous duties around the home. The need may be for vocational guidance, assessment under supervision, training, and help in obtaining employment in industry, in a sheltered workshop or at home. Outside employment is not only important for the wages earned and hence financial independence and self-respect, but also for the social contacts it provides.

8. *Recreation*

The final area to be considered is that of the recreation and social life of the patient. A keen gardener is more deprived than a keen reader by a severe coronary thrombosis. To what extent has the patient had to curtail his recreational activities and limit his social contacts? How can these limitations be overcome?

Three further points should be made. Firstly in assessing need, future problems must be considered as well as the present needs of the patient; future difficulties must be identified and planned for. Secondly, in making a medico-social assessment of a handicapped child, particular attention has to be paid to the physical and psychological development of the child. A handicapped child should as far as is possible be exposed to the same stimuli and at the same

age as a normal child, if his development is not to suffer. In adapting equipment and fitting prostheses, allowances must be made for growth and change in body shape and proportions. A child is not a small adult (Holt, 1966). Thirdly, in assessing the needs of old people, the probable presence of multiple pathologies, of vacillating mental difficulties (confusion, patchy memory and depression) and of insidiously decreasing physical power must be considered.

Prescribing Services

Prescribing services requires the same exactness of diagnosis and knowledge of the availability and function, indications, contra-indications and complications of the various services, as does the prescription of drugs. The factors that one has to consider in prescribing any of the social and welfare services are the degree and nature of the handicap, the age and personality of the patient, his past performance in life, the attitudes and resources of the family, the local availability and quality of the services, the probable delays and periods of waiting (e.g. for structural alterations or acceptance on a training course) and possible future problems.

In certain cases the patient should be referred to a specialist in one or other of the social services. It is essential to be clear whether the intention is to prescribe a service (e.g. seek the help of a home nurse) or refer a patient for advice (e.g. to a disablement resettlement officer or industrial medical officer for advice about future employment). When referring a patient for advice, the doctor should avoid pre-judging the advice that might be given. It is as irritating for a children's officer to see a patient who has been informed by the family doctor that her child is to be admitted to a home (which might not be the solution suggested by the children's officer) as it is for a dermatologist to see a patient who has been told that the specialist will prescribe cortisone ointment.

Failure to refer a patient at the appropriate time is another common error. This failure may occur because the need for further help is not recognised, because of ignorance of what other help is available, because of feelings of possessiveness towards the patient, or because of misplaced personal pride. There is no loss of professional dignity in knowing when a particular problem requires the help or advice of another worker or service. The principle and procedure are the same as a family doctor calling in a consultant or one consultant asking another to see and, if necessary, treat a patient.

The more knowledge a doctor has of the

local availability and functions of health, welfare and social services, the more able is he to help his patients and to assume responsibility for co-ordination. It is, however, unlikely that many doctors will be able to know all about all services. All doctors should at least be familiar with the range of major services supplied by the local health authority, local welfare authority, local education authority and local childrens' authority (county, county borough and London borough councils), the medical and industrial rehabilitation services supplied by the hospital service (see "Principles of Rehabilitation", by W. Russell Grant, London, 1963) and the Ministry of Labour, and the services of the voluntary bodies. It is not the intention to list these services here; reference can be made to standard textbooks of preventive and social medicine, to the Ministry of Health pamphlets prepared by the Standing Medical Advisory Committee of the Central Health Services Council and to the publications of the local medical officer of health.

Knowledge of the services must be supplemented by knowledge of the field workers. Details of their required training and the career structure within their service give some indication of what it is reasonable to expect from them. Personal contact will supply even more valuable information. It is not uncommon for doctors to expect too much of disablement resettlement officers who have only a short period of special training and who are mid-way in a career in the sense that on promotion they are likely to be only indirectly concerned with the duties of the D.R.O. Conversely doctors often expect too little from the fully trained social case-workers (medical social workers, previously almoners, and psychiatric social workers). A fairly typical view is that their duties are all a matter of giving advice which may or may not be accepted and of providing material or practical help such as arranging for children to be looked after, arranging convalescence or obtaining allowances from the National Insurance or National Assistance. There is insufficient understanding of the help and support that a social worker may have to give a family over a long period of time while services are being mobilised and a new way of life is being accepted.

Indications for Services

The prescription of the appropriate service where there is a single need is relatively simple, once the need has been correctly diagnosed. The actual service mobilised will, of course,

depend on the nature of the need. The service should support or supplement, not replace, the efforts of the patient and his family to enjoy an active and varied life. Care must be taken to distinguish the real need for a service from an unrealistic expectation of what the service will provide. Change of job may cure an anxiety state if the cause lay in personal antagonisms or other factors at work, but will not cure it if the cause lay in marital antagonisms. The provision of adequate housing can be health-giving, but it can also produce an exacerbation of problems in predisposed personalities (Warren, 1954 and 1955; Hall, 1964).

The decision between institutional or community care must be taken by the doctor, patient, relatives and social worker together. The decision is made easier if the choice lies between good institutional care and good community care. Too often it is the defects of one or other type of care that weigh the decision. The decision is also easier if it is not considered a final and irreversible decision. Institutions such as old peoples' homes should be used in a more flexible way (Morris and colleagues, 1966).

Contra-indications of Services

Any service is contra-indicated if it replaces the effort that an individual is capable of making for himself. A service is also contra-indicated if it increases the burden upon a patient and/or his family beyond a tolerable level. The family, and particularly the housewife, may become physically and emotionally exhausted, socially isolated and relatively impoverished. Tizard and Grad (1961), investigating the problems experienced by families with a mentally handicapped child at home found that the families were worse off in terms of overcrowding, finance, social life and in the health of the mother, than were families in which a mentally handicapped member was being cared for in an institution. Another contra-indication to a service is the failure of the service to achieve its objective; this may be due to an inadequacy of the service locally, wrong prescription or the personal inadequacies of the patient. Whatever the cause, failure should be accepted as the signal for a careful review of the original diagnostic assessment and prescription.

Complications of Services

Interaction of Services

Services can interact with each other in such a way that one service may frustrate or even

cancel out the contribution of another service. A common example of this type of interaction is seen in the difficulties experienced in some areas in arranging transport for patients to attend rehabilitation. A carefully scheduled full day's programme of rehabilitation for an out-patient can be completely upset without the closest co-operation from the ambulance service. An example of the nullification of one service by another is the use of an occupational therapy service to train a handicapped person in independence and in self-care, and the provision of the home nursing service to dress the patient at home; unless the efforts of these two services are co-ordinated, the situation will ultimately arise where they are working against each other. Another cause of interaction of services lies in the personality of one or other of the workers or the patient. Some personalities seem unable to work harmoniously with other personalities, with the result that conflicting advice may be given and even disparaging remarks made by one worker about the efforts of another—such behaviour can only be to the detriment of the quality of care given to the patient. Occasionally, even a fully-trained and experienced worker may lack an understanding sympathy for a particular patient or medico-social situation (e.g. an alcoholic, problem family or a recidivist) and so be unable to give that additional dimension of concern that is necessary in these complex situations. As always, treatment lies in recognition of the problem.

A final example of the interactions of services is the exploitation of different services by a patient through the "playing off" of one service against another. This can be done in many ways, the most common being "tale carrying"—the inaccurate reporting of what one worker said about another, of what one worker has requested another to do or merely of the instructions given by the last worker seen. This "playing off" is usually symptomatic of some deeper problem that has not been identified. A less significant, but still irritating, phenomenon is the "no-tell" ploy; that is, the patient does not tell the worker he is with about other people who are currently trying to help him. This is frequently due to ignorance or lack of inquiry on the part of the worker, but occasionally it is a feature of deliberate exploitation of services.

Multiplicity of Services

It is frequently suggested that if there were less services and fewer agencies supplying them, then there would be less overlap, more economical use of manpower and less frustrating

interaction. There is much truth in this suggestion; but its advocates are inclined to expect too much from a mere reduction in services and centralisation of administration. As has been discussed above, co-operation and economic use of services is not only a matter of avoiding multiplicity of visiting and overlapping of effort. Where these can be avoided without detriment to the services, then they should be avoided. But it can be desirable that there should be some overlapping of function to ensure that needs on the borderline of individual services are met, that intricate problems receive specialist attention, and that some of the work (of visiting, for example) be spread. As a previous Minister of Health is quoted in the Younghusband Report (Ministry of Health, 1959) as saying: "What is wrong is not that many people are concerned—indeed some of the more baffling problems may require them—but that they should individually think it possible to advise the family without having first worked out the co-ordinating plan of action".

Addiction

Some patients become addicted to a service or dependent on a particular worker in the service. Social workers are trained to accept a client's dependency at the start of their relationship, and later to encourage independence, but not all field workers have had training and some personalities derive considerable satisfaction from the feeling of having others dependent on them. Addiction to services can arise in other ways. One cause is the thoughtless recalling of patients for outpatient supervision, when supervision could have been left to the general practitioner or even to the patient or his family. Another cause may be that a monthly visit to outpatients is the only social occasion in the life of the patient; this form of addiction can be overcome by substitute therapy, i.e. the referral of the patient to a social centre. Addiction to various forms of physiotherapy is a well-recognised phenomenon in physical medicine departments, although the exact causes have not been identified. Basically, addiction to services arises as a result of the failure to review, temporarily withdraw or terminate a service.

Compounding Services. Case-Conferences

The combined use of health, welfare and social services in the interests of a patient involves team work; and team work depends on the attitudes and behaviour of *everyone* con-

cerned. An individual acts as a member of a group or team when he applies the same general scale of values and loyalties to his choices as do the other members of the group; when he feels confident of his own function and understands that of the other members; when his expectation of the contribution that the other members can make influences his own decisions; and when he has a clear conception of the purpose the team is trying to achieve. In order to develop this outlook and knowledge among a number of specialist field officers necessarily involved in present-day health, welfare and social services, it is most desirable that these officers should meet together. Social occasions have their place, but working case-conferences are a more effective and enduring method of developing insight, gaining knowledge and experience and of giving practical help to patients.

Case-conferences are used in a number of situations—child guidance clinics, child care service, probation service, industrial rehabilitation units, mental hospitals and in resettlement clinics for the rehabilitation of chronically sick and handicapped patients. A case-conference may meet regularly or it may be an *ad hoc* gathering called together for the purpose of discussing one particular problem. The former variety are the more useful because they are easier to utilise, more likely to follow defined procedures and working methods and they build up an expert body of knowledge based on experience.

Functions: The functions of a case-conference, in addition to that of education, are to obtain a full picture of the patient's problems, advise on possible solutions, plan and coordinate the work of the specialist officers involved and by careful follow-up to ensure that everything possible has been done to help the patient complete the plan. It is not the purpose of the case-conference to live a patient's life for him; throughout, the agreement and cooperation of the patient must be obtained.

Indications for Referral: Case-conferences are expensive in staff time. Therefore only patients presenting difficult and complex problems should be referred. Such patients will include children with severe congenital defects, severely handicapped people, handicapped people with poor personalities, aged people with multiple medico-social problems, deprived children and members of problem families.

There is a need to develop methods of identifying those patients who need the help of a case-conference as early as possible. Too often case-conferences are used as the resort

of desperate, if not defeated, field workers. As in clinical medicine, early referral improves the chance of successful treatment. In hospital practice it is possible to identify a high-risk group with two or more of the following characteristics—repeated prior hospitalization, chronic illness, old age, separation from family, poverty, unemployment, unskilled manual employment, no immediate prospect of a job upon discharge and poor knowledge of English. (A convenient, if inaccurate, screening procedure is to weigh the case-notes; when the weight exceeds 1 lb. referral should be considered.) With further study and research, methods of making an accurate medico-social prognosis should be improved. For the present, joint evaluation of inpatients by doctor, nurse and social worker is more discriminating than evaluation by one of them alone, and should therefore be widely practised.

The Patient: Only patients or families whose welfare is the common concern of all present should be discussed at a case-conference. This common concern unites the people present in their aims. The discussion of patients or families distinguishes a case-conference from a co-ordinating committee, and defines the membership of the case-conference. At some case-conferences the patient is present for some of the discussion, at others the patient is "in attendance" and is consulted as the need arises by the chairman of the conference (Warren, 1959 and 1960), and at yet others the patient does not attend at all.

Whether the patient attends the conference or not, his views must be made known to the members of the conference, and no action should be taken without his understanding and agreement.

Members: The permanent members of a case-conference include the convening chairman and the secretary of the conference. The chairman must have certain personal qualities and knowledge; his particular professional qualifications are less important. The chairman must be tolerant and sympathetic to the patient's needs and equally tolerant and sensitive to the various field workers participating in the case-conference; he must be knowledgeable about the structure and purpose of the health, welfare and social services and the training and qualifications of their various staff; and he must be capable of clear, orderly thinking, able to relieve tension, clarify contributions, promote fruitful discussion but courteously curtail the irrelevant, analyse, integrate and sum up the conclusions arrived at. In hospitals the Ministry

of Health advised (Circular (58) 57) that the chairman should be a consultant on the hospital staff, but he could be a general practitioner or a medical officer of health (Warren, 1965). The secretary of the conference should be a social worker.

The other members of a case-conference will vary with each patient discussed, but all present should be involved in the care of the patient or family. In regard to hospital patients the consultant (or his registrar) who is in charge of the patient's clinical treatment should certainly attend as also should the general practitioner and on occasions the industrial medical officer. The ward sister, physiotherapist, occupational therapist, field workers from the relevant departments of the local authority (health visitor, home nurse, welfare visitor, children's visitor, etc.), disablement resettlement officer, field workers from the voluntary bodies and others may be present. The list is formidable; but not all the people mentioned are likely to attend any one case-conference. The "team" will vary with each patient—hence the key-role of the chairman and secretary. Much of the success of a case-conference will depend upon the ability and knowledge of the organisation by the secretary. For it is her duty to arrange the timing of each case-discussion so that those who should be present can be present, and so that no one is kept waiting while a case he is not concerned with is being discussed.

Members of statutory or voluntary committees should not normally attend case-conferences, at least not in that capacity. Case-conferences are concerned with the individual's problems and not with coordinating general policy.

Confidentiality: Each person attending a case-conference must be assured about the confidential nature of the discussion and the security of any records kept. Without trust based on this assurance, helpful discussion is hardly possible. All the professions accept this obligation of confidentiality, but it is essential that it be preserved in administrative and committee proceedings.

Procedure: The members of the conference are introduced to each other. It is surprising how often one meets field workers who know of each other but who have not previously met. The chairman summarises the details and problems to be discussed and invites contributions from those present. The intention is to pool all the information available about the diagnosis,

treatment and prognosis of the patient's condition, the patient's remaining abilities (and disabilities) and capacity and aptitude for learning and training, the patient's personality, motivation and inclinations, the attitudes of his family, his family and home circumstances, his employer's attitude and details of the patient's entitlement to sick-pay, retirement pay or compensation, local and national training and employment opportunities, details of rehabilitation units, convalescent homes and hostels and the probable delays that may occur in utilising any of these facilities. If the patient has been discussed previously, progress achieved and any material change in the situation will be reported. The various "facts" some of which may well appear to conflict are discussed and assessed so that, as previously mentioned, as clear a picture as possible is obtained of the real situation and the patient's view of it. This discussion of the facts should clarify and define the basic problems so that a plan of treatment and social care can be outlined.

The plan aimed at must:—

- (a) Be acceptable to the patient,
- (b) Be within the limits of the patient's mental and physical capabilities,
- (c) Offer reasonable security and prospects of advancement,
- (d) Be compatible with local opportunities.

Planning a policy of treatment and after-care should begin at the time of the first consultation about that particular illness or injury. The plan should be a guide and may have to be modified in the light of progress. After identifying the needs of the patient the next step is to decide which of the various agencies must be brought in, when each is to be brought in and, equally important, when each is to withdraw. The contribution of each agency is then re-considered to ensure that there is no unnecessary overlap of effort or duplication of visiting and interviewing. Responsibility for taking action and for reporting back on progress must be clearly stated and accepted.

Follow-up should continue until a period of stability has been achieved after the completion of the plan. Follow-up may continue for many years, as in the case of a congenitally handicapped child, but it should not be necessary to reconsider the individual patient very frequently after completion of the initial stages of the plan. It is not usually necessary for all field workers to attend follow-up discussions. If the original plan is working out satisfactorily those not present can be informed of progress

by letter or telephone; if unexpected difficulties have arisen, another full scale case-conference can be convened later.

Other Recommendations

This paper has concentrated on the problem of calling-in, directing and integrating to-day's health, welfare and social services in the interests of a patient and his family. The purpose of such use of services is to enable the patient to become more confident and to make his own progress towards a renewed independence, or if this is not possible, to provide the most suitable supporting help, interlocked with the contributions that the family (if any) can make. But to-day's situation is not immutable, and therefore some farther recommendations are made to extend and to simplify the use of services.

Anderson and Warren (1966) have demonstrated the failure of many doctors to use reference books listing the availability and range of health and welfare services. Some doctors, later found to have such books, were unaware that they had ever received them. The first recommendation, therefore, is that medical students should be encouraged to use reference and information books and booklets and not be expected to learn up a lot of details about services. Certain reference books should be permitted in the final examination.

The present services are confusing to understand and variable in quality. In every major local authority area there should be Advisory Centres staffed by trained social workers to which anyone can go (or telephone) who needs social help or information. Referral to the appropriate agency would be a vital part of the task of such centres.

The quantity and quality of services varies across the country. Minimum permissible standards of provision based on better definitions of needs and functions, coupled with more research, demonstration projects and effective evaluation of the services should raise their quantity and quality (Morris and colleagues, 1966). But such research is not simple, for basically it must measure improvement in social productivity and the quality of the patient's life and contentment through the provision of a whole range of services.

Finally, it is to be hoped that the present committee (under Mr. F. Seeböhm) reviewing local authority personal social services and the proposed Royal Commission on the structure of local government will be able to suggest how the present confusion of social services can be rationalised.

Summary

Treatment should include the use of welfare and social services, but recent studies have shown that available sources of help are frequently not used. The reasons for this are the complexity of the services, the lack of knowledge on the part of the doctor and the failure of the patient to comply with instructions.

The first step in using services is to make a medico-social diagnosis of the patient's total situation. In intricate cases, this should be done at a case-conference. The needs of physically, mentally and/or socially handicapped people have many common elements. These should be systematically reviewed under the following headings: (i) Full medical and/or surgical treatment; (ii) Psychological adjustment of the patient and his family; (iii) Independence in self-care; (iv) Income; (v) Accommodation; (vi) Mobility in the home and outside; (vii) Occupation; (viii) Recreation.

The indications, contra-indications and complications of services must be considered. The prescriber must decide clearly whether he is ordering a service or seeking advice about a service. Cooperation is engendered more by the latter than the former. Patients must be referred at the correct time and to the correct service and preferably by personal contact with the field worker concerned. Services are contra-indicated where they replace a justifiable effort of the individual, intolerably increase family burdens or fail to achieve their objectives. The complications of services include interaction resulting in diminution or even nullification of result, exploitation by patients, over-visiting and addiction.

Where a number of services are to be used, a case-conference is indicated. Only people who know and are concerned with the treatment of the patient should attend. The permanent members are the chairman and secretary, the other members are those concerned with the patient. The conference pools all information, discusses a plan of treatment, allocates functions and follows up the situation of each patient until optimum resettlement has been achieved.

The material in this paper is based upon my experience as consultant-in-charge of the Resettlement Clinic, Royal Free Hospital, from 1959-1964. Throughout the tenure of that post, I was given immense help by Miss S. T. Hart, M.A., Chief Medical Social Worker, to whom I express my very sincere thanks.

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