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BLUMENFIELD, Susan, 1941-
COUNSELOR-ASSISTANTS FOR A GERIATRIC PROGRAM IN A COMMUNITY HOSPITAL.

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SUSAN BLUMENFIELD

1977

COUNSELOR-ASSISTANTS FOR A GERIATRIC PROGRAM IN A COMMUNITY HOSPITAL

by

Susan Blumenfield

A dissertation submitted to the Graduate Faculty in Social Work in partial fulfillment of the requirements for the degree of Doctor of Social Work, The City University of New York.

1977

This manuscript has been read and accepted for the Graduate Faculty in Social Work in Satisfaction of the dissertation requirement for the degree of Doctor of Social Work.

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ABSTRACT

COUNSELOR-ASSISTANTS FOR A GERIATRIC PROGRAM
IN A COMMUNITY HOSPITAL

by

Susan Blumenfield

Advisor: Dr. Eugene B. Shinn

A program utilizing senior citizens was developed in a community hospital to give service to patients of a similar age group. The program was designed to strengthen performance of the humane and unpredictable services necessary in a hospital, while providing an opportunity for the productive use of time for older people by using them as the service givers, or counselor-assistants.

This dissertation describes the process of preparing hospital personnel for implementation of this new service. The recruitment and selection of volunteers are discussed, as is the development and implementation of the one-month training program. The experiences of the seven "graduates" are described as they worked with patients for the three-month pilot phase. Their supervision by social workers and group meetings with the program director are discussed.

Evaluation questionnaires or structured interviews were administered to all participants in the program.

The program was found useful to the people involved. Some specific tasks expected that the counselor-assistants would perform, were not needed by patients, but the availability of this person to

give companionship and perform a variety of unpredicted services was helpful. The volunteers all reported satisfaction and pride in their work.

Recommendations are given for continuation and modification of this program.

ACKNOWLEDGMENTS

It is with a sense of excitement and joy that I view the completion of this dissertation. It describes a lengthy and very personally involving process of seeing unmet needs and attempting to provide one way to address them. Yet, there could have been no progress at all if it were not for the input and help of many people along the way. I would like to here give thanks to those whom the following mention can only be a token of the deep gratitude and affection I feel for them.

To the Doctoral Faculty and my colleagues, I give thanks for making me part of a stimulating program. New ways of thought and a push toward creativity certainly began here and will, I hope, continue as a result of my experience in the program.

My committee has been most helpful and supportive. I thank Dr. Irving Weisman for his helpful suggestions and ever calm interpretations of the vicissitudes of program planning. I am grateful to Mrs. Mildred Mailick for her expertise about hospitals and training and her ability to offer support and empathy for my efforts. Dr. Rose Dobrof was most helpful with her vast experience with the aging and stores of warmth and support of which she liberally gave. I thank her also for continuing to be a strong role model. I have unbounded gratitude for my chairman, Dr. Eugene Shinn, for not only his clear thinking, expertise and help, but also his support and belief in me

through even the most difficult times. How important it was to have him always available and always able to make suggestions that would help me overcome obstacles which occurred.

No thanks to the Doctoral Program would be complete without mention of Mr. Myron Hulse, our Executive Secretary, whose kindness and efficiency made large problems shrink away and small inconveniences disappear. He created a "home" on the seventh floor and a "family" of the participants in the Doctoral Program.

Together with the intellectual and emotional input from people at the Hunter School of Social Work, I received important practical help from many others. I would like to thank Mrs. Esther Mallack, Director of the Mental Health Association of Westchester, for allowing me to work with her. It was her original concern for older patients which led to the possibility of formulating this project. Mrs. Helen Kramer, Chairman of the Geriatric Committee of the Mental Health Association, gave invaluable support to all my efforts for which I am very grateful.

Mrs. Carol Rocklin, Director of Social Service at White Plains Hospital deserves special thanks for her belief in me and in the program as it developed. If it were not for her support both emotionally and in time and effort, this program could never have been effected. The generous backing of the social work staff, Victoria Assuma, Mary Ann Quill and Carol Hermance, was also instrumental in producing this program.

Many thanks go to the counselor-assistants who were willing to try something new, give service where it was needed and teach me so much about the work we were doing.

Most of all go thanks to my family. My children, Jay, Bobby and Sharon, never let me take myself too seriously. The balance they give to my work is inestimable in maintaining my perspective. My husband, Michael, has always supported ever more serious commitment to my work. Both by being available to discuss ideas, read papers and suggest alternatives, and being ready to offer encouragement and belief in me, he surely has had a part in this project as well. It is his unfailing love and support that has truly made my work possible. For all of this and more--a public thank you!

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CHAPTER I

INTRODUCTION

> Intelligence, and reflection, and judgment, reside in old men, and if there had been none of them, no states could exist at all.
>
> Cicero - De Senectute XIX

Cicero made his observations about old men approximately 60 years B.C. Have people changed so radically or our perceptions become so altered that our society might yet mouth these words, but feel they refer only to exceptions? Some lip service is given to the "judgment" or "reflective" abilities of the older adult, but social policy in this country, in our recent past, has been directed toward isolating, discarding and generally not using or enhancing the abilities of our older citizens.

Yet, we are entering a new era. "Consciousness raising is becoming a rallying cry and each raised voice of each new group seems to affect those around it. Within the clamor, we are hearing some protest for the rights of the aged. Perhaps a bit feebly, at first, as has been proper for our older citizens, but in the din, the shouts have become stronger and erstwhile beginnings can be seen in grappling with the "problems of the aging."

Just how a society attempts to deal with any felt "problem" is a reflection of its own history, psychology and present image of itself. In the United States today, adrift as we are in a morass of deprivation and uncertainty, predictions of how our social problems

will be met are impossible. We must be aware of the risk, that in a time of limited resources, proposals for change that are meant to increase the quality of life can be subverted to lessen human service.

Given this picture of present society flux, and awareness of the discomfiture of the aged, let us put ourselves briefly into perspective before discussing the specific areas which will be addressed in this project.

We are confronted with abundant literature from studies of other cultures which show us that societies deal with lifestages very differently. Although human development follows a distinct course, i.e., sucking before chewing, crawling before walking, etc., the time spans for each stage, the rights and duties therein, and the relative importance of each varies from culture to culture and from one generation to the next. Simone deBeauvoir in her book, The Coming of Age,[1] describes in great detail how many primitive societies differ in their treatment of the aged. From great deference and high value placed upon grey heads and stooped frames, to total derision and subjugation, once the older member was no longer physically powerful, all seemed alike in their view of their elders as a group apart. In common, they had the function of transmitting knowledge and culture, but the liability of less production and more need.

At present, this scientific era that produces longevity, also produces technological advances for keeping and transmitting records, far more efficiently than by word of mouth from old to young.[2] Rapid changes in techniques made "the wisdom of age fall victim to the up-to-dateness of the downy cheeked recent graduate."[3] Age--that which was once rare, and valued or feared--has come around to being very

prevalent and suddenly a new burden on the mobile, striving middle class society. In the industrial world, unemployment is a chronic problem. Mandatory retirement ages are one way of dealing with it. A young man, without a job is "unemployed," while an old one is "retired." Thus, our statistics can be balanced toward productive youth, while minimal social security allowances are set aside to salve the old.

Daniel Sambol, Director of the Aging Division of the Protestant Welfare Agencies has remarked:

> Extending lives has not always brought reason to make living worth while . . . the elderly have become too often an unwanted minority group which has frequently accepted the negative attitudes of the young and have embraced destructive attitudes of self-contempt and self-hatred. Too many don't question society's view that the elderly are no different than automobiles or beer cans. After being used they are expendable and can be discarded.[4]

Today there are more than 20 million people in our country over the age of 65 years. They are increasing in numbers more rapidly than the population as a whole, and the average age within this group has increased. The proportion of people over 75 years in 1900 was 29 percent of the elderly. In 1970 it was 38 percent.[5] The number of years of retirement for older men was three times as great in 1961 as it had been in 1900.[6] It is a fact that withdrawal from the labor force results in a large drop in income and concomitantly that among the various age cohorts in the United States, the incidence of poverty is greatest in the 65 and over cohort.

What does this perusal tell us? We are confronted with a population that is increasingly getting older and up to now the very fact of chronological aging has been seen to produce a kind of discriminatory neglect.

The sociologists have turned from faithful acceptance of Parson's theory of the nuclear family as being the ideal family type for a mobile society.[7] There is recognition of the prevalence and functional role of the modified extended family in which parents and dependent children share a home apart from grandparents, but a series of exchanges exists among the separate units of the kinship system. Research, even cross-culturally has supported these views, so that we see the elderly not only as non-productive discards from the labor force, but as a functional part of intergenerational linkages with family and friendship groups.[8] This brightens the picture, somewhat, but it does not go far enough in enhancing the common view of, or attitudes toward this group.

In a booklet entitled the Aged and Community Mental Health, the Group for the Advancement of Psychiatry stated: "The negative stereotype of the aged and biases against them are typical in our society. Without special attention this sizable group is likely to be neglected.[9]

It is the special attention necessary in order to gain equality with the rest of society that has become of concern to me. Out of this concern has come the concept of developing a special service in one area where special attention is surely necessary.

The following dissertation describes the perception of this unmet need and the development of a two-pronged program to answer it. The need involves the difficulties for the older person as hospital patient. Included in this is the fact that he or she often gets less interested care and suffers from an overabundance of technology with a loss of humanity. Using the theoretical framework of Litwak's

typology of organizations and types of tasks therein, which will be discussed later, a program was developed to meet these needs. The program attempts to employ a generally unused resource in meeting the needs which in turn addresses another need--that of the retired older person to use his leisure productively. The program, "counselor-assistants for geriatric patients in a community hospital," involves using older people as volunteers to provide specific services for older patients. The older volunteers or counselor-assistants were to be recruited, trained and then used to provide links between patient and hospital, by providing companionship and performing specific "non-uniform" tasks for patients. The program to be described is not an alternative to services already given at the hospital. It is in addition to them. It is an attempt to provide an adjunctive service to more fully address the special needs of the older patient.

Social workers and the patient representative at the hospital provide social, emotional and institutional supports for patients at the hospital. Their specific roles provide essential help in the patient's adjustment to illness, to the hospital and in plans following discharge. As we will discuss, however, the special needs of the older hospital patient necessitate special attention. It is with this "special attention" that the services of the counselor-assistant are concerned. Such a person can perform those tasks that are not of a technical nature--the "non-uniform" tasks which contribute to the patient's well-being, but do not have to be done by the professionals.

The fact that counselor-assistants are older adults themselves leads to their having specific attributes in relation to older patients.

They are of a similar generation and on the same intergenerational level as such patients. Their life space and pace of doing things and thinking may be similar. Older adults interested in working in such a program will have blocks of time available to be distributed as needed. Mature judgment and experience wisdom which often develops with age are also elements which will be needed in helping older patients. These attributes together with the training given in the program for working specifically with older adult patients is the basis on which the counselor-assistants can give the special services. The fact that they are performing a useful and important role can contribute to their own self-esteem and morale.

The following pages will discuss more fully the background and development of the counselor-assistant program. Starting from broader coverage of the "unmet need" we will look at the theoretical and value framework which formed the basis of the design of the program to meet that need.

Following this will be a discussion of the process involved in program initiation, implementation and institutionalization. An evaluation and summary will complete the dissertation on the counselor-assistant program developed to meet an unmet need of older hospital patients, by employing a generally unused resource of interested older people from the community.

Footnotes

[1] Simone deBeauvoir, The Coming of Age (New York: Warner Paperback Library, May, 1973).

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CHAPTER II

NATURE OF THE UNMET NEEDS

The disadvantaged status of the aged in indistrial society has been well-documented.[1] In many areas the old have received less than their "fair share" and it is a recent occurrence that concern with this is growing in our country. For the purposes of the project described here, there are two disadvantages suffered by the aged which are of interest. One is the poor social and psychological treatment they receive in acute treatment hospitals. The other is the absence of opportunity for the productive use of time.

Poor Treatment in the Acute Care Hospital

In no place is the plight of the aged more needful of special attention than when they require medical hospitalization. The old are the group most likely to use medical facilities and are the group which spends the most on health care. They often suffer from chronic ailments which are ill-suited to treatment in the acute care hospital as it has evolved up to this time. Combined with these problems is the negative image of the elderly and its effect on hospital care. The following will discuss these issues.

Frequency and costs of care for the old

Older people will at some time find themselves in need of hospitalization. "Older people have high rates of illness and dis-

ability and a high demand for health services."[2] They make up a large proportion of people cared for in hospitals and need longer and costlier care than the under 65 year old population. In 1973, the average length of hospital stay for those 65 and over was 12.1 days. For those 15-44, it was 5.7 days.[3]

"In 1973, people 65 and over, who made up 10 percent of the population, accounted for 28 percent of the $80 billion bill for personal health care that year."[4] The average bills for hospitals and physicians were three times greater for the over 65 population than for other adults. While public funds accounted for two-thirds of the total expenditure for health services to older people, in 1973, the individual older person still could expect to have only 40 percent of his health bill paid by the government.[5]

The figures representing utilization of hospitals by people over 65 years will only increase as the proportion of old people in the population increases. Brotman stated that "by 1990, every tenth American will be over 65 years (27 million people). Forty percent of these will be over 75 years."[6] Since increasing age particularly over 75 is documented to bring increasing ills, hospital usage must increase considerably.[7]

The old are frequently recipients of health care in hospitals, but often their problems tend to be chronic and degenerative rather than acute. Thus, their needs do not mesh well with the modern system of health care.

The old and chronic illness

Almost one-half of the entire population is said to suffer from one or more chronic illnesses. Such illness is highly associated with advanced age and low incomes.[8] The gain in increased longevity has produced the cost of "increase in the chronic and degenerative diseases associated with aging."[9]

The chronic nature of many of mans ills as he reaches old age have implications for the kind of care he needs. Chronic illnesses are by definition, long term, and as such require "forms of organization suitable for repeated interaction over months, and years between patients and health workers and for the complex social relationships which grow up between them over the course of the illness."[10] The hospital is oriented toward short-term diseases. Chronic care is disruptive to its normal operations.

Chronic illness needs proportionally more efforts at "palliation"[11] There are usually no fast cures, but rather attempts to relieve symptoms and discomforts. The long-term nature of such illness requires cooperation of the patient in his own care and often an ability of the patient to accept changes in his functioning. Thus efforts at palliation must include help with anxiety and grief as well as efforts to control downward course of disease and pain. "Since patients must learn to live with their symptoms, palliation becomes an important part of the overall treatment technology, as does care of medical or quasi-medical problems ancillary to primary disease."[12] Yet, such palliative work is not always seen as medically necessary and appropriate in the

environs of the acute care hospital. Balance between patients needs, physicians opinion of best care and regulatory agencies edicts on what can be funded is difficult to obtain. In the face of chronic illness, as suffered by most older people, this balance generally precludes the necessary palliative care, including attention to the myriad of ancillary services.

Organization of the acute care hospital

As we ponder the concern for the care of older patients in the acute care hospital and begin to lose patience with a system that would so short-change the old, we must step back and gain some perspective on the evolution of the modern hospital.

> Progress in medical science and in the specialized division of medical skills has changed medicine from an individual intuitive enterprise into a social service. The hospital is the institutional form of this social service. It has evolved from a house of despair for the sick poor to a house of hope for all social and economic classes in just the past 60 years.[13]

With this radical change which has so aided the fight against disease, however, has come the change also from the original meaning of the word itself. "Hospital" comes from the Latin hospes, meaning "host" or "guest". John Knowles notes that the words hospital, hostel and hotel were once used interchangeably reinforcing the view that in a hospital, one was a guest, whose needs were met.[14] Modern hospitals developed with the advent of Christianity. Monks practiced medicine in hostels near the monastaries.[15] In the 10th and 11th centuries only the hopeless, the destitute or travelers came to hospitals. By the 1700's in England, the monastary system was suppressed and two

hospitals were founded on a secular basis, thus forcing these facilities to limit their work to the curable sick.[16] "This was the first time that the hospital had taken up an active, curative role in medical care."[17] Most care was nursing and the palliative concerns were highest. Death rate was high and wealthier patients were still treated by the physicians who came to their homes.

Growth of private philanthropy established the first voluntary or privately endowed hospitals in the 18th century and in the 19th century, teaching hospitals were founded in England. These were the prototype of those that arose in the United States.[18] The growth of cities was the stimulus for the development of the American hospital. Need for care and people to provide that care were concentrated into cities. In the late 1800's and early 1900's, several discoveries led to the ability of the hospital to produce more cures than deaths from infection, surgery, etc. These included discoveries of antiseptic techniques, ether as an anesthetic, chemicals to prevent blood-clotting, X-Ray techniques, and development of antibiotics.[19]

> Following World War II, the centripetal effects of a rapidly expanding medical technology that could be based only in the hospital and an increasing utilization of physicians by a steadily expanding population pushed both the patient and the physician closer to the hospital.[20]

The general hospital today is a highly technical, high cost, acute care institution. The sub-division of labor has increased with the rise in technological advances. But this has caused a "fragmented 'machine' approach to the patient and dehumanizes what should be an intensely personal and humane encounter."[21] The evolution of the hospital from palliative house for the poor and weary, to high-powered

curative center for the ill has undoubtedly been advantageous for mankind. It is the spin-offs from this evolution that stimulates some nostalgia for just a piece of the palliative qualities that once existed, particularly in the care of the old and chronically ill.

Negative image of the elderly

Because of the stereotype in our society, we are ready to accept illness and discomfort as a part of aging. Medical personnel react less quickly to the non-emergency request of the older patient. He is easily written off as "just old" and therefore incapable of much help, or seen as "senile" and non-functioning when the hospitalization itself may have caused the confusion and concern. Few clinicians have received adequate training for geriatric practice and still fewer are ready to give the necessary psychotherapeutic time and concern to such patients.

The stereotype of the older person in society is often mirrored by the health care personnel in the hospital. That the older person is too old to understand, contribute to planning for his care, or unable to respond to his surroundings are often accepted as givens, and no attempt to counteract these phenomena are made. The fact that confusion can be a temporary result of illness is often not acknowledged. The apathy shown by many older patients is accepted as disinterest and not investigated as a form of depression which it often is and for which intervention can be helpful.[22] Younger patients seem to engender more frequent and more interested contacts with

health care personnel than older patients. More hopefulness is expressed for the younger patient and more creative planning goes into their aftercare.

Robert Kastenbaum describes the unconscious impediments of the psychiatrist to working with older patients, and they seem to be extendable to regular physicians as well. He discussed the fact that the aged are a low-status group and therefore treating them can be seen as a low-status pursuit.[23] The fact that time and energy are seen to be invested in a "transient and doomed enterprise" which is in our society less valued also contributes to the need not to get too involved in treating them.[24] The very chronic nature of many ailments allows for less satisfaction in their treatment than dramatic cures or life-changing interventions with a younger patient.

It is the older patient who appears more often in the beds of the general hospital and who in order to get the care due him must have special attention to his needs.

Absence of Opportunity for the Productive Use of Time

Another area of special need for older adults is the opportunity for using time productively. A major problem among the aged is "having too much free time." The proportion of older people who say that they do not know what to do with their time increases with age.[25] In our society where the age of retirement has been lowering and the life span increasing, there are more and more years available to people without organized work.

Juanita Kreps points out that when Thorstein Veblen wrote _The Theory of the Leisure Class_, only those in the leisure class had money. Not to have money meant that one worked.[26] In today's society free time has been generated by growth in output. Such free time has been allocated to retirement. People over 60 years of age have an abundance of time free from work for pay, even though they, in fact, have very modest incomes.[27] "In contrast to earlier decades of this century, when the increase in free time was taken in shorter workyears, mid-century allocations of working time began to shorten worklife."[28] What this means, of course, is that years accruing to people at the end of worklife will increase. Leisure is one portion of economic growth that is very unevenly distributed. Those in the work force are under ever greater pressure to produce, while the old frequently forced to retire, have ever greater portions of leisure.[29] "Regardless of whether free time has utility to the retiree, the amount of time so designated constitutes a major potential resource which can increasingly be turned to various uses: recreation, public service, education, work, if jobs are available."[30]

It is with the need of how to use this resource of time that we are concerned. Low morale frequently accompanies retirement.[31] Lowered income is an ever present spectre. "The disadvantaged position of older people arises not from the fact that they have less real income than the previous generation of older people, but that they are likely to have less income than they themselves enjoyed in working years and have less income than those still at work enjoy."[32] This very real situation contributes to low morale at retirement and must be addressed by society. In a small way, beginning conceptions of

this project attempted to provide a position that would add, albeit slightly, to the income of the retiree participating. However, beyond the need for increased income, there is also a need for providing opportunities for older people to be challenged and to be productive.

There are those workers who find retirement an escape from an "undesirable , unsatisfying work role."[33] Nearly half of the blue collar workers in a study by the University of Michigan's Survey Research Center for the U.S. Department of Labor, felt that at age 50 they would retire if they had enough income to live comfortably. Less than a fourth of the white collar workers felt this way.[34] Studies on adjustment to retirement show a variety of results which depend on the health status and physical capacity of the retiree, expected income, current occupation and the economic conditions at the time of the study.[35] Yet, in 1969 in a study by Virginia Reno, it was found that half of the people aged 62-65 who retired compulsorily would not have wanted to do so.[36]

How people react to retirement or any life stage cannot be generalized. The fact that there is some clinical evidence to support that some individuals are badly affected exists. In some people, anxiety and depression accompany such a change. Psychosomatic symptoms can take hold and can "heighten with the confusion of roles, activities and changes in the structure of one's life that develops at the time of retirement."[37] These can worsen if no satisfactory life style and work substitutes can be found.

While the case cannot be made that retirement leads to isolation, or to mental illness, it can be stated that for some people adjustment is difficult. Even for people who have not been in the

labor force, societal shoves toward being seen as less productive are conducive to lowered self-esteem and apathy.

While not everyone over the age of 60 years is concerned about how to use their leisure time, many have such concerns. Options have to be created for a variety of ways this resource can be used. One option can be creation of jobs, whether volunteer or paid, that are service-oriented, in keeping with skills of many older people toward "counseling and teaching,"[38] and appealing to attributes within particular personalities.

The creation of just such work seemed to be an area of need for one segment of the older population and could fill the need of another and sometimes interchangeable part--the older hospital patient.

Evolving Proposal

Given the nature of these unmet needs, it was felt that based in the hospital could be a cadre of older personnel who were especially knowledgeable about community resources for the older person and trained in facilitating linkages between such resources and the people who can use them.

The needs of all older patients are not the same. As in any other life stage, each person is an individual. The personnel placed to give extra services to the older patients would have to be very aware of this fact, and their role would be very much determined by the needs of each individual patient. For the patient with many assets of good functioning, close family ties and supports, just an awareness that a person with particular knowledge and concern is available might be all that is necessary. In a case where the patient is rather

isolated or frightened, more could be offered by way of companionship, help and advocacy, even to the point of a type of family surrogate continuing beyond the hospital stay.

Illness can be viewed as a crisis. Social and psychological intervention at the time of medical aid can be crucial to recovery and continued health. At this life stage, arrangements must be made to cope with deficits which accrue in the life of the older person.[39] The Group for the Advancement of Psychiatry reported that the older patient may need concerned people to fill needs which were fulfilled more in the past by family members. He may need activities which can help him maintain his sense of purpose and self-esteem. He may need to reorganize his environment to make up for organic deficits which have occurred. The older patient needs understanding, reassurance, help in speaking up for his needs and assistance in using community services. He needs help in obtaining those small and unpredictable needs during his hospital stay. He is often in a position of being more needy and yet receiving less help.[40]

We also see many older people as needing opportunities for productive use of their time. To have these people use their time to help other people at time of interface with the medical setting seemed a desirable way to meet both needs at once.

If we acknowledge the existence of less than equal treatment for aged persons and if, ethically, this is deemed unacceptable, attempts at change are obligatory. The proposal I began to suggest and shall elaborate further, was one small attempt to move in the desired direction of more appropriate service and an increment toward viewing the older person as of value.

Footnotes

[1]For one of the more recent accounts, see Robert Butler, _Why Survive? Being Old in America_ (New York: Harper and Row Publishers, 1975).

[2]Ethel Shanas and George Maddox, "Aging, Health and the Organization of Health Resources," _Handbook of Aging and the Social Sciences_, ed. by Robert Binstock and Ethel Shanas (New York: Van Nostrand Reinhold and Co., 1976), p. 593.

[3]U.S. Department of Health, _Health, U.S. 1975_, Public Health Service, Health Research Administration, Department of Health, Education and Welfare Publication Number (HRA) 76-1232 (Washington, D.C.: Government Printing Office,), 513, 573.

[4]Shanas and Maddox, "Aging, Health and the Organization of Health Resources," p. 594.

[5]_Ibid_.

[6]Herman Brotman, _Who Are the Aged: A Demographic View_, Occasional Papers in Gerontology No. 1, Institute of Gerontology, University of Michigan, Wayne State University (November, 1968), p. 2.

[7]Shanas and Maddox, "Aging, Health and the Organization of Health Resources," p. 598.

[8]Elihu M. Gerson and Anselm L. Strauss, "A Time for Living: Problems in Chronic Illness Care," _Social Policy_, 6: 3 (November-December, 1975), 12.

[9]John H. Dingle, "The Ills of Man," _Scientific American_, 229 (September, 1973).

[10]Gerson and Strauss, "A Time for Living."

[11]_Ibid_., 14. [12]_Ibid_.

[13]John H. Knowles, "The Hospital," _Scientific American_, 229 (September, 1973), 128.

[14]John Knowles, _Hospitals, Doctors and the Public Interest_ (Cambridge, Mass.: Harvard University Press, 1965), p. 3.

[15]Knowles, "The Hospital."

[16]_Ibid_. [17]_Ibid_.

[18]Knowles, "The Hospital," 129.

[19]*Ibid.*, 130. [20]*Ibid.*

[21]*Ibid.*, 132.

[22]Sidney Levin, "Depression in the Aged: The Importance of External Factors," in *New Thoughts on Old Age*, ed. by Robert Kastenbaum (New York: Springer Publishing Co., 1964), p. 179.

[23]Robert Kastenbaum, "The Reluctant Therapist," in *New Thoughts on Old Age*, ed. by Robert Kastenbaum (New York: Springer Publishing Co., 1964), p. 143.

[24]*Ibid.*, p. 139.

[25]Marjorie Fiske Lowenthal and Betsy Robinson, "Social Networks and Isolation," in *Handbook of Aging and the Social Sciences*, ed. by Robert Binstock and Ethel Shanas (New York: Van Nostrand Reinhold Co., 1976), p. 443.

[26]Juanita M. Kreps, "The Economy of the Aged," in *Handbook of Aging and the Social Sciences*, ed. by Robert Binstock and Ethel Shanas (New York: Van Nostrand Reinhold Co., 1976), p. 281.

[27]*Ibid.* [28]*Ibid.* [29]*Ibid.*, p. 282.

[30]*Ibid.*

[31]Marjorie Fiske Lowenthal, Paul T. Berkman and Associates, *Aging and Mental Disorder in San Francisco* (San Francisco: Jossey-Bass, Inc., 1967), p. 259.

[32]Kreps, "The Economy of the Aged," p. 274.

[33]Harold L. Sheppard, "Work and Retirement," in *Handbook of Aging and the Social Sciences*, ed. by Robert Binstock and Ethel Shanas (New York: Van Nostrand Reinhold Co., 1976), p. 303.

[34]*Ibid.* [35]*Ibid.* [36]*Ibid.*, p. 305.

[37]Butler, *Why Survive?*, p. 72.

[38]*Ibid.*, p. 80.

[39]Group for the Advancement of Psychiatry, *The Aged and Community Mental Health: A Guide to Program Development*, Vol. VIII, Report #81 (November, 1971), p. 46.

[40]*Ibid.*, pp. 47-50.

CHAPTER III

THEORETICAL AND VALUE FRAMEWORK

Application of Theory of Coordination of Uniform and Non-uniform Tasks

We may view the plight of the older person vis-a-vis the general hospital within the theoretical framework suggested by Eugene Litwak.[1] He suggests that formal organization (hospital) and primary groups (the patient's family and friends) are separate but interacting entities. The former is a repository of technical and large scale resources which can engage in highly specialized tasks within suitable hierarchical order. These are referred to as "uniform tasks." The latter or primary group is that which provides the humaneness and warmth. It can best handle tasks which involve unpredictable events, those for which ordinary experience are adequate and those tasks which are widespread and extended over time.[2] These are designated "non-uniform" tasks.

Litwak and Meyer give us a typology of formal organizations which can help to further define the place of these tasks within the four types of organizations. The models they propose are extrapolated by R. Dobrof as follows:[3]

1. Rationalistic Model is most like the bureaucracy of Weber. Activities are specialized, governed by rule and organized to fulfill clearly defined duties. Reward is based on merit and hierarchy of control prevails.

2. Human Relations Model is smaller in size and general goals and purposes are the basis for staff actions. It is collegial rather than hierarchical, and relationships can include personal elements. Reward is still on the basis of merit.

3. Professional Model has elements of both Rationalistic and Human Relations Models. The function of such organizations include both "uniform" and "non-uniform" tasks. This mixture contributes to its goals and effectiveness, but imposes a strain both within the organization and upon those external to it with whom it must deal.

4. Non-Merit Model is a bureaucracy but is the least formal. It is characterized by mixture of rationalistic and non-rationalistic operations and has many characteristics of a large primary group.

As we look over this typology to see where the acute care hospital might fit it becomes clear that it belongs to the category of the Professional Model. Within the hospital are a variety of disciplines which interact both collegially and hierarchically. An abundance of clearly defined activities for specific purposes exist as well as many tasks dealing with unpredictable and human relations issues. There is an attempt to harmoniously mix the variety of tasks to produce a symphony of optimal care for the patient. It is my contention after viewing the acute care hospital, as it is superimposed on the needs of elderly patients, that discordant strains have emerged.

In the professional organization, compartmentalization or departmentalization occurs to try to deal with the strain of balancing the "uniform" and "non-uniform" tasks. In hospitals, departments of social

service, were developed to take on service partially for some of the "non-uniform" needs of patients. Greater technology and more complex systems to be negotiated have led such departments to more and more performance of "uniform tasks." The volunteer departments and patient representatives also function in a hospital to service "non-uniform" needs of patients. For the younger patients such services have worked somewhat to mitigate the "tyranny of hospital structure toward technical services," i.e., parents or surrogates can stay overnight with children; volunteers play games, bring toys to youngsters, etc. For older patients with differing needs, however, there is an imbalance in the performance of "uniform" and "non-uniform" tasks.

The patient is brought to the hospital because he or she is ill. All the science and technology of the hospital are to be brought to bear upon eradicating or alleviating the patient of his disease. In so doing, a variety of technical or uniform tasks are necessary and the institution or hospital has contained within, the expertise to carry these out. At the same time, those non-uniform or humane tasks performed by the primary group for the patient have shrunk in relative importance before the giant of illness and the arsenal of tasks needed to treat it. While, initially this may be necessary, very soon the discomfort of older patients in the form of fears, disorientation and confusion is apparent and the institution and primary groups can be viewed as having become too distant. The primary group cannot operate effectively within the confines of the hospital to perform all those non-uniform tasks so essential for well-being. Personnel in the hospital in its present structure have so many uniform, technical tasks to perform that they cannot take on the non-uniform or personal ones.

We can think of this situation graphically as the arms of the institution reaching out and those of the primary group also reaching, but not quite able to touch and enfold the patient. In order to alleviate this situation, we can insert an extra link holding onto the institution, but also performing primary group functions and reaching toward the patient. This time, in our picture, the uniform tasks performed by hospital personnel and primary group tasks performed by an extra link provide more ideal service for the patient.

The nature of that link which we propose to insert must be very specific in order to produce effective coordination. That person who forms this link, must perform partly primary group tasks, but must have some special expertise within the context of the organization. In this way, the gap in coordination between effective services for the older patient and the reception of these by him can be closed. The balance can be restored and the needs of the older patient more fully met.

Litwak's discussion of the detached worker as a linking agent is useful in our discussion of bringing non-uniform services in the hospital closer to the patient.[4] While the use of the "detached worker" is not to link hospital to primary group which would be similar to Litwak's use, we use this concept as a way to orient us to the mode of operation of such a linking agent. Such a worker operates informally. Relationship is allowed to develop through face-to-face and often unscheduled meetings. Positive feelings develop and are used in giving help. Mutuality is underscored and the relationship can endure over time and in many areas of life. These aspects of the detached worker's role embody the attachments to primary group and in

this case to the patient, and are inherent in providing special services to the older patient in the hospital. Yet, they are not complete without specialized knowledge in the area of interviewing techniques, self-awareness, special resources and how to obtain them, which inhere in the institutional connection of the detached worker, i.e., new personnel proposed for the hospital.

Given knowledge of the separation of tasks, I was interested in trying out the concept of the "trained semi-primary group member" as an aid in linking institution to patient. "Semi-primary group member" would refer to a person who could empathize and identify with the older patient; could almost interchange roles as it were. This person, although not a friend or neighbor, would be more or less a contemporary of the patients and would have shared some similar life-experiences, putting him into the category of a "semi-primary group member." He would be asked to feel with, understand and become involved in the concerns of the older patient. He would be able to perform unpredictable, personal tasks for the patient. Yet, he would be asked to do this, only after a period of training in which he learned to acknowledge his own feelings toward himself, aging, helping and being helped. He would learn what resources for older people exist in the community and how these can be obtained. He would be helped to use the resources he already brings from his maturity and life experiences in order to help others. It is this training which would allow the "semi-primary group member" to be employed in the hospital and to provide service to the patient in the form of attending to non-uniform needs.

The view of lack of balance between hospital and older patient

suggests the realignment of this balance as a remedy. It is within this context that my proposal emerged to train a small number of selected people 60 years and over to work with older patients in a community hospital.

The Use of the Older Worker or Volunteer

The elderly are already involved in giving much service on a voluntary basis.[5] It has been said that "many older people can and wish to remain responsible and contributing members of the community, either as part of the labor force or as volunteers. Unless it is possible for them to do so, the community loses the value their experience and maturity can contribute to the enrichment of community life."[6] Unless they have outlets for productive life, their motivation for living and self-esteem can decrease considerably.

Looking at the experience already in operation like SERVE and RSVP in which senior citizens give service in groups to a variety of agencies,[7] we are aware of the commitment and usefulness of participants. The Foster Grandparents program[8] also involves senior citizens as volunteers. Here they agree to become a surrogate grandparent for a child who has none of his own.

In other programs involving service by older adults, the workers are paid. I had originally hoped to have participants in our program paid in like fashion. In Manhattan, the International Ladies Garment Workers Union runs a program of visits by paid retirees to other retirees which has been functioning for ten years.[9] PATH has been training and sending out a number of senior citizens to visit

shut-in people of all ages at their homes.[10] In Westchester, the Senior Personnel Employment Committee gives some training and employs seniors to be what are called "Paid Neighbors." In that role they go to homes where people need the service of light housekeeping and companionship and have been very effective in giving both.[11]

In applying the linkage theory in serving older adult hospital patients, using people who are volunteers rather than who are paid is an issue more for the givers of service than the recipients of the service. Initial planning, as will be seen in Chapter IV, included obtaining money to pay the senior citizen workers. This was hoped to add another dimension to their satisfaction and give tangible evidence of the worth of what they were doing. When this proved unfeasible, the suggested program was made still possible by asking senior citizens to volunteer to do the variety of tasks seen necessary in providing the new service in the hospital. The application of the theory and the value underpinning of providing an additional service to older patients were kept intact. The secondary goals of providing new training and an area in which to use the services of the older adult were thus attended to.

William Posner, one of the pioneers in gerontology, had a vision of old age as a stage in life that had a future; an era from which one would not have to shrink with dread, but toward which one could aspire.[12] By enforcing mandatory retirement, discarding the old ways for the new, we have been profligate in our wanton destruction of a major natural resource--people.

The more programs we initiate to provide education for all ages, to allow training or retraining of any interested people,

regardless of age, the more we are moving toward a world respecting the abilities of all.

Issac Asimov, in his article on age as it will be viewed by the year 2000,[13] feels that "society will have to alter its youth-centered attitudes." The much larger percentage of older adults which will occur through lowering population growth and increasing longevity, will make this change inevitable. He makes a plea for changing our view of some basic institutions like education. If education is confined to the young alone, he reminds us, the "elderly retain the attitudes, beliefs, and cliches of another time." A cycle of depriving "post youth of socially approved opportunities to learn allow the faculty of learning to atrophy."[14] The self-fulfilling prophecy of not being able to teach the old, thus continues. He feels that what we view as the incapacity of older people to learn is due to the fact that they themselves have always assumed they would be increasingly incapable of learning as they grow older. In a society where it is taken for granted that the opportunity to learn will never be denied, we might find very different self-images.

> With the opportunity of changing careers, of trying different sublifetimes in one extended one, of knowing that radical changes can be made at any time and that there will be time for a full preliminary education in preparation for each change, men and women can retain the qualities of creativity and eager innovativeness all through their lifetimes.[15]

Asimov tells us that this post-youth society he foresees will occur within the lifetimes of individuals alive today. Thus, he urges a revision of our attitudes toward age to begin now.

The scenario he presents is the secondary value component of the project under discussion here. It would be a small move in the

direction he suggests; that of education in later life, new careers and attempts at constant revitalization.

Value Base Behind this Project

Major value underlying the program

The major value premise underlying the introduction of the project to be described in the ensuing pages is that of the right of all patients to good medical-social care in the hospital. In an area where a segment of the population receives less than adequate attention, extra service is needed to bring this group in line with others. The project instituted here, is an attempt to fulfill this gap in service to older patients. It has at its base, the value that were service distribution is unequal, extra service should be given to the less advantaged group.

Secondary values important in the project

Other values addressed in a peripheral way in the project to be described, are the right of older adults to receive training and to be continually useful. To provide the non-uniform tasks which seems to be lacking between a community hospital and the older patient, I suggested an older adult. The knowledge base behind selecting a peer group person to give aid includes successful work done with many self-help groups and awareness of how empathy can be more readily produced where some parallels already exist between people.[16] The bond of age group is a strong one. Living within the same era, having experienced

similar life stages and even facing similar crises can produce great empathy.

Older people have been seen as very capable in giving service. It is within the human services field that maturity and experience are most helpful. If an interested, alert, capable older person is given training to prepare him to work with other people in the hospital, he could provide a very important and useful role.

This is not to say that someone over 65 years is the only one who could perform the service suggested, but is to say that such a person could most capably be trained and used. The preferences for using another age group could easily be discussed, but the possibility is only noted here. The rationale behind this is the value assumption that age should not deter anyone from outlets to learn, to give service, or to enjoy self-esteem. In the program I proposed, to enhance the balance between non-uniform tasks for the patient in the hospital and the technical, professional ones, I felt it urgent to also address, albeit in a small way, the need for changing the image of our older citizens. The image of pathetic discards from the market, depressed and discouraged, has to be incrementally attacked with programs encouraging new uses of older people. For us to think of our older citizens as productive, vital people, we have to facilitate the emergence of new alternatives for them.

Given the knowledge base and value orientation behind this project, we can now discuss the design of the actual program.

Footnotes

[1]Eugene Litwak, "Some Principles for Guiding Agency and Family Linkages in the Provision of Neighborhood Services" (paper presented at the Symposium on Neighborhood Service Delivery, Community Service Society, October, 1974), p. 7.

[2]Eugene Litwak and Henry Meyer, School, Family and Neighborhood: The Theory and Practice of School-Community Relations (New York: Columbia University Press, 1974), pp. 7, 8.

[3]Rose Dobrof, "The Care of the Aged: A Shared Function (unpublished DSW dissertation, Columbia University School of Social Work, 1976).

[4]Litwak and Meyer, School, Family and Neighborhood, p. 158.

[5]Ruby Sills Miller, Helping the Volunteer Get Started: The Role of the Volunteer Center (Washington, D.C.: National Center for Voluntary Action, 1973), p. 8.

[6]Central Bureau for the Jewish Aged, Dynamic Factors in the Role of Caseworker in Work with the Aged (New York: Central Bureau for the Jewish Aged, October, 1961), p. 41.

[7]Janet Sainer, "Serve: Older Volunteers in Community Services" (New York: Community Service Society, 1971).

[8]In this program, as in those run by SERVE, participants are given expenses incurred when engaged in the volunteer activity.

[9]I.L.G.W.U. Friendly Visitors program is one of the services offered through the Union Retirees Service Department. Retired members paid $2.30/hour visit retired workers about once a year to check how they are doing and encourage continued union connection. Visitors meet every two weeks for in-service training. In 1972, the program was extended to visitors who go to nursing homes each week to become companions to and do service for retired union members who are residents there.

[10]Personal Aides To the Homebound is a program sponsored by the Federation of the Handicapped which began in 1965 under an O.E.O. grant. Its objective is to wage a "two-pronged attack on economic and social poverty of two large populations, the elderly poor, and the homebound, residing in the five boroughs of New York City. Men and women over 60 years of age are trained and placed in paid employment as PATH aides. The PATH program now, not only trains such aides, but also operates a placement service to help secure jobs for the elderly in New York City.

[11] Senior Personnel Employment Committee runs a large "Paid Neighbor" service, but acts as a general employment agency for seniors as well. There is no fee to either employer or employee, as the Committee is supported by foundation and federal funds. It attempts to open up employment opportunities for seniors in wide diversity of fields.

[12] Central Bureau for the Jewish Aged, Dynamic Factors in the Role of Caseworker in Work with the Aged (New York: Central Bureau for the Jewish Aged, October, 1961), p. 41.

[13] Issac Asimov, "The Coming of Age," Prism, 3: 1 (January, 1975), 55.

[14] Ibid.

[15] Ibid.

[16] Ibid., 56.

CHAPTER IV

BASIS OF THE DESIGN OF THIS PROGRAM

It is knowledge and value which ultimately lead to professional practice.[1] When the piece of practice is to develop a program, these elements are basic in understanding how and why the program was designed in a specific way. We must ascertain the goals of the project and the program and look at what informs the process of reaching them.

The project goal is distinguished from the program goal by noting that the first refers to the overall guiding outcome for which efforts are devoted. The second defines the outcome of the attempt to develop a specific service. These goals operate from the base of knowledge and value.

The knowledge piece is contained in "propositions"[2] or "if - then" statements based on accepted theory or fact. In this case, these propositions are developed out of the "balance theory of coordination." The value basis of program design which Dr. Harold Lewis refers to as the "ethical imperative"[3] is the moral commitment for undertaking the work. Such a commitment leads to the "commendation" or the decision that efforts should be undertaken to meet the moral commitment. Ultimately "principle" derives from the combination of knowledge and value and suggests what practice should occur.

The following will illustrate how the principle is derived on which this program design is based:

Project goal

To apply the balance theory to develop a way of performing non-uniform tasks by developing a new service.

Program goal

Utilize the balance theory to enhance the care of aged patients in the hospital through legitimation of the linkage function (that of providing non-uniform tasks) using aged workers.

Propositions

1. If an organization is in the "professional model," both "uniform" and "non-uniform tasks must be performed.

2. If an institution performs both kinds of tasks, there should be some balance between these.

3. If "non-uniform tasks" are not performed satisfactorily, a new personnel with this responsibility can be created.

4. Many older workers have maturity, judgment and ability to provide special services.

Ethical imperative

Equal access to (1) health care, and (2) service opportunity for all, requires special attention to those most likely to be denied access, including the aged.

Commendation

Develop a service using older workers which will enhance the care of older hospital patients.

Principle

When an imbalance occurs in service delivery, a new linkage should be provided to enhance the care given. Use the resource of those previously unused to provide new linkages.

Scope of the Program

Based upon the theoretical background and value orientation as stated, a program was designed to address the unmet need that had been identified. The scope of this program can be looked at by discussing resources involved, both men and material, questions to be raised, and the feasibility judged at the outset.

People involved

The people involved in the program besides myself included staff of White Plains Hospital and members of the geriatric committee of the Mental Health Association of Westchester. Although hospital administrators, physicians, nurses, head of volunteers were all somewhat involved, the social service director and staff were the mainstay of the program. The geriatric committee proved to be a sounding board for new ideas regarding the program and a basis of support in going through the steps of implementing it. Of most importance to the

project were the older adults who were interested in, and selected to volunteer in the program, and the older adult patients to be served.

Material resources involved

Although the program was designed originally with the plan of being self-supporting via outside grant money, lack of success in obtaining funds changed the thrust. Rather than having a half-time program coordinator responsible only for the program, time had to be allocated from regular casework duties to administer the program. Rather than workers who were paid a wage compatible with still maintaining social security coverage, we had to recruit people who were willing to volunteer.

These changes drastically altered the material resources needed. Instead of operating with a $40,000 per year budget,[4] the project in this way, operated with no major money outlays. Space, office supplies, xeroxing, secretary and social work time were all given to the program through the social work department by the hospital. Other staff people gave time to lecture during the training phase and outside speakers from other agencies gave time to come to training sessions to lend their expertise.

Variables to be looked into

In doing this project, we are dealing with a multitude of variables and possible interactions. Yet, there are a few of note that will be looked at more closely in the discussion of the actual program. These are the following:

1. Peer group interaction among the elderly as a linkage function.
2. The older hospital patient.
3. The older volunteer worker.
4. Participation of social workers in a new service.

Questions to be considered

In doing such a project in which knowledge is applied and made the basis of a new program, we will be considering several questions. Discussion of the actual program should cover some answers to these:

1. How do we provide the climate that will enable a program of using older adults to give service in the hospital?
2. How do we train older adults to work with older adults?
3. How can one promote linkages between institutions and patients, and community resources and patients?
4. What linkages can be made by older adult counselors which are feasible within the context being studied?
5. What qualities within the population studied seem to make for the best outcome?
6. What qualities of the older patients being served seen to enhance their ability to use the new service?
7. What kinds of interactions occur between the counselor-assistants and the patients, their families and hospital staff?
8. What are the needs of older hospital patients as identified by the group of older counselor-assistants?
9. Does the new service provided, have relevance to the needs of older hospital patients?
10. Can a small pilot project generate interest in producing further programs of this type?

Possible unexpected findings

As a by-product of the development of the program, answers to other questions might begin to emerge. The following are examples of such possible questions:

1. What are the best methods for teaching linkage skills to older adults?

2. Does this service compete with service in existence in the hospital?

3. Are qualities the older person brings to this job more important than what he learns in the training phase, in fulfilling his linkage role?

4. Are there specific qualities which inhibit performance in this role?

Feasibility

Before embarking on the venture which shall be described in the ensuing chapters, some assessment had to be made of the feasibility of the proposed program. Initial proposals were drawn up and several months spent in discussing these with social service directors in hospitals within Westchester County. Once it was known that White Plains Hospital was interested in the program, the goal of providing a new linkage service seemed feasible. In such a context, it seemed both timely and appropriate.

Timeliness

Demonstrating a linkage function to provide more effective service for the older adult medical patient seemed to fit in with the general context of the times.

The numbers of people living to ages 65 years and over has been rapidly increasing in recent years. At least 20 million people in the United States are over 65 years and of these, 38 percent are over 75 years. Not only have their numbers and attainable ages increased, but due to lowered birth rate and better medical care, the proportion of older adults in our population is steadily increasing. The problems associated with such population changes have been documented for many years,[6] but it is within the very recent past that stated national policy has included attempts to alleviate the social pitfalls of growing older.

Public attention is presently focused on the elderly. The news media has picked up on such things as nursing home scandals, or the preventable deaths of older people who froze or starved to death within their own homes. A new awareness has occurred among the general population regarding the "plight of the aged," reaching even to the last Pulitzer Prize which was awarded to Robert Butler for a book documenting the vicissitudes of aging.[7] There is even a beginning ray lighting the darkness of denial in relation to the inevitability of the aging process in all of us. Alex Comfort has often remarked that the aged are one group against whom prejudice is directed, that those expressing the prejudice, must themselves eventually join.[8]

During the past year the Administration on Aging in Washington, D.C. was sponsoring efforts at increasing public awareness of aging, while enhancing the image of healthy and productive older people. T.V. spots, special programs, proliferation of articles and the like are at work attempting to focus attention on our older citizens.

Given the climate as has been described, the program which I

had proposed seemed very timely. It was in keeping with efforts to provide greater service to older people, particularly at the point and location where they need it. The project also planned the utilization of capable, interested older adults in providing this service, which maintains the view that aging itself is not a disease process, but a still-useful stage of life.

Concomitant with interest in the aging is the increasing public pressure for broader and more effective health care. Since the older person is frequently a recipient of hospital care, the extent and effectiveness of such care is coming under greater scrutiny. A program to increase services in this regard was thus of special interest at the time.

National attention, public concern and a hospital ready to try a new program, pointed to the timeliness of such an undertaking.

Appropriateness

Trying to demonstrate the linkage of the older patient to the institution seemed appropriate to do within the context of the community hospital. Older persons are often in need of medical care and hospitalization. It was appropriate therefore, that there be people specially trained in the needs of the older adult as part of the hospital services. Thus, at point of contact with the institution for medical care, the older patient could be offered special service to help with concomitant social and psychological needs. Although this was within the aegis of the social service department, the service offered was an additional and very specific one for the older hospital

patient. Because of the interest shown by the White Plains Hospital in incorporating such a service, it appeared to be an appropriate facility in which to demonstrate the proposed program.

The particular linking function, which I suggested that the older patient needs, could be handled by another older person whose particular attributes help him to empathize with and advocate for the older patient. Adding training to the attributes the older person brought to the job allowed him to use himself more effectively. He was attached to the hospital structure, yet could function more flexibly because of his role than regular social work staff. He could spend more time with older patients while they were in the hospital and provide a special type of relationship. The trained older person had an appropriate role as a kind of hospital "detached worker,"[9] i.e., working under the auspices of the hospital, but using flexible and innovative ways of linking patients to hospital and community resources. By his having been under hospital jurisdiction, he obtains sanction and support in fulfilling his role.

The Mental Health Association of Westchester, which is, in the main, an advocacy agency, became aware of the needs of the older patient in medical settings and initiated work on attempting to deal with this lack. Because hospitalization is a crisis point for any individual, particularly the older person, good mental health care at this point is of major importance. The Mental Health Association appropriately became concerned about this issue.

I became involved in the attempts to answer the felt needs of older medical patients, via my participation on the geriatric committee of the Mental Health Association. My personal concern in this

area was a major reason why it was appropriate for me to design this program. I had been involved with mental health work for several years and had had experience in medical settings. This combination made the incorporation of concepts from each, feasible for me to do. In designing a program for older hospital patients, comfort with family interaction and with all hospital personnel was a prerequisite. Since I felt that I brought these elements to the task of using knowledge we already have to create a new program, it was appropriate for me to work on this area.

Given the interest, the groundwork and the agreements of the Mental Health Association and White Plains Hospital to work together with me, such a combination to produce a program seemed most appropriate.

Objectives of the Program

In preparing the program to be described, there were several objectives to be met:

1. Develop a receptive context in which to demonstrate use of the older adult to provide a linkage function for older adult patients (Initiation Phase).

2. Develop a group of persons to provide the new service (Implementation Phase).

3. Develop a mechanism for trained counselor-assistants to provide linkages between patients and hospital, community resources and families (Institutionalization Phase).

4. Evaluate the difficulties and strengths evident in the other objectives.

Summary

The foregoing has given the background thinking and preparations that were needed to produce this program. With the combination of an unmet need, a knowledge base, value implications and now a basis for the program design, we are ready to look at the program itself in detail. In the next three chapters the initiation, implementation and institutionalization of the program will be described. For each phase, an attempt will be made to look at how and why tasks were performed and the ways participants reacted to them.

Footnotes

[1]Harold Lewis, Lecture given at Hunter College School of Social Work, New York, N.Y. in Spring, 1975.

[2]*Ibid.* [3]*Ibid.*

[4]See Appendix A for mini-proposal. Proposed budget is on page 8.

[5]U.S. Department of Commerce, Social and Economic Statistics Administration, Bureau of the Census, *We the American Elderly*, No. 10 (Washington, D.C.: Government Printing Office, June, 1973).

[6]See varieties of popular magazines, newspapers. Front page article in *The New York Times*, Sunday, February 6, 1977 dealing with changing age representations in the population.

[7]Robert Butler, *Why Survive? Being Old in America* (New York, Evanston, San Francisco, London: Harper and Row Publishers, 1975).

[8]Alex Comfort, statement made in lecture given at symposium given by the American Geriatrics Society, September 15, 1976; see also: Alex Comfort, *A Good Age* (New York: Crown Publishers, Inc., 1976).

[9]See: Eugene Litwak and Henry Meyer, *School, Family and Neighborhood: The Theory and Practice of School-Community Relations* (New York: Columbia University Press, 1974), for discussion of detached worker.

CHAPTER V

INITIATION OF PROGRAM

Planning

Early steps toward initiation of change were begun when the problem was identified. It was at this time, within the context of the Geriatric Committee of the Mental Health Association that I submitted an early proposal for a program to provide a linkage service for older patients in medical hospitals. The committee was eager to see such a program begun and under M.H.A. auspices, I met with directors of social service departments in the various hospitals in Westchester. Although some showed interest, only the White Plains Hospital heard the proposal with a desire to help to implement it.

Attempts were made to obtain funding for comprehensive planning of the program, but planning continued despite the lack of such funds. I met with the director of social service at White Plains Hospital to expand and revise the proposal for the program and to explore new possibilities for future funding. Periodic reports were made to the geriatric committee of the Mental Health Association of which I was a member, to continue to involve community representatives dealing with the elderly in thinking about and giving support to any implementation of our program.

Meetings were held by the director of the social service department of the hospital with the president of the Board of Governors and the Chief Administrator of White Plains Hospital in which the program

was discussed. Both executives were most interested in the idea of further serving the increasing number of elderly patients. Although the hospital has a policy of retirement at age 65, the idea of doing a pilot project using people over 60 years, as service givers was acceptable since the hospital was not to be employing these people. We appealed to the administration concerns for additional services, strengthened public image and need for investment of little in resources. Both executives were impressed and were eager to have the program begin.

Search for funding. With the acceptability of the proposed program to the interested agencies, attempts were begun in earnest to find outside funding. Upon suggestions from people in the field, specific foundations interested in aging, were contacted by letter. A mini-proposal (see Appendix A) was included each time a request was sent, which gave a summary of the project rationale, design and cost. Unfortunately, this proved a frustrating effort, in that no real commitments were forthcoming.

Responses to our requests indicated interest, but not priority. One foundation was already heavily involved in funding one service in Westchester and could not take on another. A different foundation felt that program was not a top priority item.

While the private sector was rejecting the request, I also contacted representatives of the public agencies. I began to have meetings with the director of the Office of the Aging in Westchester who seemed most interested in our proposal. He agreed to jointly sponsor, with the Mental Health Association, a request for Title IV research and development funds under the Older Americans Act. The representatives

of these groups were not able to get together on this plan and a potential source of funding was not fully explored at this time. The director of the Mental Health Association felt that through her personal relationship with state senators, the proposal would be more likely funded with their support. We sent letters and copies of the proposal to the state legislators and ultimately were referred back to the Westchester Office of the Aging.

With a change in Director of the County Office of the Aging, a last attempt was made to obtain government funds to implement the program. I met with the new Director to explain the proposal, and although he showed great personal and academic interest in it, he felt that the lowered funds now held by his office had to go to programs involving food, housing and transportation. Employing older people to give an extra service to older hospital patients, was seen as a lower priority item. Written material was presented to him and some possibility of future help was held out.

Involvement of White Plains Hospital. During this period of "frantic fund finding," discussions were also held with the hospital social service director to continue interest in the program. I also began to spend time at the hospital to become involved with the social work staff to encourage their participation in thinking about the coming program. The proposition that people involved in decision-making will more likely act in accordance with the decision made, was constantly in mind as I spoke to hospital staff regarding the proposed program. Not only were informal meetings held with the social workers, but I took the opportunity when meeting other staff, particularly nurses and

doctors, to discuss the program and invite comments and ideas. While still unsure of the ultimate auspice of the proposed program, I was attempting to work with both the informal and the formal organizational networks to provide a receptive climate for the implementation of the pilot project.

These early forays into the hospital, revealed a myriad of sub-systems, conflicting philosophies and interpersonal conflicts between people who would be called on to all give support to a new program coming in. Social work skills of listening, empathizing, and remaining non-judgmental were most necessary in attempting to create a cooperative base for any new venture which would impinge on several departments.

By this time, the full weight of failure in obtaining funds was upon me. The alternative to carrying such a burden was to create a new way to implement the program in a seemingly now-receptive environment. This involved changing the concept of "gainful" employment, to "voluntary" labors for all the participants. The Director of the Mental Health Association was in favor of continuing to pursue funds, but discussions with her and then with members of the geriatric committee of the Mental Health Association, produced grudging blessing to go ahead with the project in any possible way. For these discussions, revised notions of the feasibility of the different slant to be given the program were important. Because the older people to be working in the program could not be paid, some of the tenor and rationale of the project would be changed. Still, it seemed important with the extensive community and hospital groundwork laid that the project to provide

meaningful and growth-producing work for seniors in an area of need, be continued.

The hospital director of social service agreed to try to have me implement the program with volunteers. There was a strained relationship between the social service department and the hospital volunteer department and the social service director was concerned that a program using volunteers would have to include work with the hospital volunteers. I agreed to meet with the director of volunteers to sell the project idea anew.

In September, 1975, both the director of social service and the director of volunteers submitted their resignations to White Plains Hospital. There was an ensuing question of who would be taking over, and how the new people in power would now deal with the question of pursuing a new program. Even though the program had been formally accepted by the administration at the top of the organization, its status was so unsure at this point that I requested direct contact with the Hospital Administrator before the social service director left. Since the administrator's contact with the proposal had been through this social service director, I felt it was most important to provide a new bridge to relate him to the program to help insure its acceptability. Coincidental with this plan, was the resignation of the part-time worker from the social service staff.

By now, I was aware of how precarious it was to try to implement a program with little base of power from which to operate. Because I had been unable to bring in outside funding and fall into the role of having control over what total package was offered to the hospital, I was now finding myself only an outsider, completely dependent

upon a now-shaken foundation of support.

Given the changed situation, I felt that in order to be sure of implementing the proposed program, action needed to be taken to insure commitment on the part of the hospital. To this end, I suggested to the outgoing social service director that I could be hired by the hospital as their part-time caseworker with the stipulation that part of my hours be devoted to implementing the project. She agreed to this plan and to my request that she set up an appointment for me to meet with her and the hospital administrator to discuss this proposition.

Obtaining a Base of Operations

I was able to present the suggestion to the administrator of filling the part-time opening at the same time that he would be assured of the department working to implement a program he and the Board of Governors of the Hospital had been awaiting. He seemed comfortable in hiring me with the agreement that part of my time would be devoted to the project, but felt that it would ultimately be left to the discretion of the personnel director and whomever was hired for the job as social service director. I then had meetings with the personnel director who appeared also interested in my proposal of working part-time and also implementing the project.

The choice of a new social service director fell to one of the social workers from the department. This was a very qualified woman who had gotten to know me and was well aware of the project proposal. She was eager to implement various changes to produce a tighter

department and was ready to try innovation in the form of the new program as well. It was on this basis that I was hired and became a member of the social service department at the Hospital. My dual role as caseworker and project director were agreed upon at the outset and work proceeded from there.

At the same time that I was hired, a new full-time worker was also hired to fill the vacancy left by the newly appointed social service director. Soon after all these changes, the one other worker left and was replaced by another new full-time worker. The base from which to promote the new program was thus strengthened. The old foundation had cracked, and rather than insecure patchwork, there was now a rebuilt and stronger one in its place.

The social service director was committed to realigning the department, and changing its image in the hospital. She saw the implementation of the project as one means toward this end and had made the commitment to work on it by hiring me. The two full-time workers, hired after me, were brought into a department already committed to change and innovation and were thereby ready to accept a role in helping to implement a new program. Thus, the new base of operations seemed secure and ready to take further activity.

Working as a caseworker in the hospital, I was able to really understand hospital needs and to informally apprise many staff members of the planned program to be implemented at the hospital. In the course of working with a variety of doctors, nurses, aides, housekeeping people, etc., I was able to discuss our ideas about using older people to help in the hospital. At the same time that people became aware such a program was contemplated, they were able to give reactions

to the idea and feel a small part of its planning. Because of the huge numbers of people working in the community hospital where communications channels are weak and convoluted, we reached only a part via these informal channels, but I felt this was an important aide to eventual acceptance of a new idea.

Use of variety of communications channels. Harold Guetzkow has spoken of several channels of communication within interdisciplinary organizations.[1] In these initial forays into the organization, I, as staff social worker with the ultimate plan of implementing a small change, certainly used various networks simultaneously as Guetzkow suggests. Guetzkow's model allows for communications to flow from one professional to another via routes of "authority, informational exchanges, task expertise, friendship and status."

In setting the stage for reception of the new program, there was implicit use of the channel of authority as the program had the backking of hospital administration and social service director. Informational exchange channels developed around day to day working with patients in the hospital, also allowed discussions about the proposed program. The route of task expertise was helpful in defining needs seen by staff and clarifying the role social service has in helping with these. Over time, friendship channels became very important in supporting our work both with patients and in smoothing the way for the new service to begin. Such channels were most operative with floor nurses, aides, home care and utilization review workers and physical therapists. During the several months of preparation to implement the

program, many staff members became supportive both professionally and personally.

Constraining influences. There were not only positive aspects to the base of support I then had. Many constraints appeared as well. Because of the nature of the private community hospital that this is, social service, as a department has had an uphill battle for recognition. Its rather dingy offices on the lowest level, surrounded by laundry and garbage, as well as clinic and pharmacy, graphically represent its location in the hearts and minds of planners.

All patients treated at the hospital have their own personal physicians who make brief visits to supervise care the patients receive from the nursing staff. There are no organized rounds on each unit. Rather, the huge numbers of physicians come in when available and confer with nurses at those times or by phone regarding patients care. Communication with the social workers is also very much by phone, augmented by notations in the patients chart by each party. Such a wide variety of personalities to deal with, compounded by the lack of overall policy on interdisciplinary relationships makes for difficulty in communications. The private physician is very much in charge of his patients' care while in the hospital. Social service as an adjunct to that care is variously viewed on the whole gamut of outright hostility, some suspicion, acceptance or wholehearted welcome depending upon the particular physician. With no organized meeting ground, communication and relationships with the physicians generally proceed on a case by case basis. Social service is most often requested by physicians in discharge planning either to help in arranging home services, transfer

to rehabilitation hospitals or nursing home placements. The acceptance and use of the social service department as introducing a pilot program, therefore, could be hindered by erroneous expectations on the part of physicians. This had to be recognized when using the social service department as a base of operations for the new program.

Further constraints imposed by being a member of an already existing department in the hospital were prior experiences of other staff with our previous staff people. Some of these had been most negative and I, in trying to implement the program, as well as my co-workers in dealing with patients, were confronted with the need to prove we were a new, active, involved department with particular expertise. Because of a rather dormant period just prior to all the social service personnel changes, time and effort were needed in the beginning to cast a new image. Anticipation of the proposed program both suffered from old associations and then contributed to this new image.

A further complication built into working in this environment was the physical plant itself. The hospital was and is in the process of construction and change. Plans for a new wing had been in the offing and construction proceeding when I joined the hospital staff. Access to areas was physically impeded because of this and with completion of some sections and moves of departments, patient units, etc., general upheaval and uncertainty added to the general pressures of hospital existence.

For me, having a place on the hospital staff and an agreement with administration and social service, provided the necessary base of operations. From this I could work to involve the various parts of the institution and surrounding community, as well as learn firsthand

more of the needs of patients and care givers. Without outside funding, such a base was a necessity, yet it was this very base which provided the largest constraint of all--time! The heavy involvement necessary in doing the day to day job with patients, allowed no extra time to really work on implementation of the program. Aside from informal communications and concomitant changing the image of the department, there was no way to bring concerted effort on producing the program. Heavy caseloads pressured each social worker and being part-time, only served to increase this pressure for me. As much as my base allowed me to become a real part of the institution for which the program was proposed, there grew the danger that too much entrenchment over the first few months would preclude my being able to implement the program at all.

Full Commitment from the Hospital

The social service director and I carefully discussed my proposal for the new program and together tailored it to meet the needs of the department as well as the hospital patients. We set up meetings with the administrator responsible for our department to apprise him of our readiness to begin and our need for time to do so.

During several meetings, I had to outline our plan again to use older volunteers to provide specific services for older adult patients. Through a series of memos following the verbal interchanges, I discussed the timeliness and feasibility of attempting to implement the program in the spring and summer. Such factors as the opening of the new wings of the hospital, the advisability of innovation at the

time of such physical changes, and even the good weather as an aid to accessibility were factors taken into account. With all these communications, we were basically asking that the hospital provide the funds to keep me on staff for two months, working only on the project, while also providing a social worker to handle my caseload during that time. The request for two months was to allow one month for me to work on recruiting volunteers and organizing a training program and the second month to run the training program to prepare the volunteers for their job in the hospital.

The commitment of the hospital to the program proved strong, and my requests in order to implement it were met. I developed a timetable of activities to give to the administrators so they could be aware of our planning and process. The administrator to whom we are directly responsible continued to meet with us periodically to monitor progress and to be available for further negotiations. Discussions were held in such areas as time allotted for the training program. It was agreed that four weeks would be allowed for this process. The social service director and I felt that it was important for the hospital to provide lunch for participants during the training phase, even though the hospital does not do this for any other volunteers. Our plan was to have people come from 10 a.m. to 2 p.m. on each of two days a week and to use the lunch hour as part of the training. It took a lot to convice our administrator of the need for this. Once he agreed, however, he was able to have our whole plan approved by the Hospital Director and a date was set to begin work on the program.

Congruence of program and hospital goals. In looking at the negotiations necessary to obtain time to initiate the program, we have to be aware of some of the principles employed. From the very introduction of the proposal to the hospital administration there had to be an awareness of the multiplicity of goals within any complex organization. Perrow discusses "official goals" and "operative goals."[2] The official goal of a community medical hospital is to provide a therapeutic environment for healing the sick. This broad, generally acceptable purpose given for the existence of such an institution is dependent upon the operation of a myriad of interacting disciplines and values. The "operative goals" or ends sought through actual operating policies of the organization, also have to be recognized and addressed when attempting to produce innovation of any kind. When discussing the use of older volunteers to provide a linkage function for older hospital patients, this had to be dealt with in terms compatible with organizational goals. The increasing numbers of hospital patients over 60 years had to be stressed, along with the increasing social, psychological and financial problems concomitant with illness in this group. We had to strongly address the proposition that the environment for medical care could be improved by providing an extra social service. Theory relating social and emotional factors to health care, had to be coupled with stress on the value of giving extra service to a group which frequently receives less. In short, the goals of the proposed new program had to be seen as keeping to the overall goal of the organization.

Some of the implicit goals in the community hospital are keeping costs down, avoiding complaints and lawsuits, moving patients

through the system with rapidity, keeping peace with the multitude of physicians practicing there and projecting a progressive image. Although these are not explicitly stated anywhere, after working within this institution, these operating goals within the administration become apparent. Negotiations around program implementation had to address these. While the proposed program was a modest addition to hospital service, the public relations value of being the institution to initiate it was stressed. The fact that the hospital could point with pride to giving thought and time to providing more for its older patients was judged to be good publicity. Built into the agreement to allow time for implementation was an agreement that we would seek and work on publicizing the change. To go along with the goal of keeping costs down, we asked for the minimal cost of providing one extra part-time salary for two months. Otherwise, innovation could occur within the boundaries of existing space, services and the use of volunteers. Although we could not promise faster movement of patients, nor concur wholeheartedly with this implicit goal, we could and did suggest that extra service might, as a consequence, address this goal. Having informally polled some physicians regarding the program, during negotiations with the administration we could point to positive response and agreed to requesting permission from key staff committees to go ahead. Fitting our proposal and value system into both the explicit and implicit organizational goals was most important in obtaining administrative support and backing from the hospital. In this way we were obtaining the authority, resources and sanction for implementing a new program within an existing organization.

Completion of these negotiations marked the successful conclusion of the initiation phase in producing innovation.[3] The objective of producing a receptive climate for change seemed to be reached. Through the formal structure of the organization, support was obtained from the top, both in attitude and resources. Through the informal networks, ideological and verbal support was obtained within other hospital staff.

The very active support of our new social service director was most important within our own department, as well as within the hospital hierarchy. The fact that our department would be actively involved in producing the new program was evident from the top down. Goals of the program enhanced those of the social service department. Being able to offer more service and that of a very special type was a value shared within the department. Planning an activity that would engage older people in serving a useful and valuable role fit in well with social work values of human dignity and worth. Our secretarial staff of one full-time and one part-time secretary were involved from the beginning in sharing ideas and vicissitudes. Acknowledgement of the need for the extra work they would have was made. There was some question as to the ultimate cost to our department, but the director was agreed to measuring outcome and costs after at least trying the pilot project. She was willing to invest time and energy and set the tone for all three workers involved to do the same. Both because of her personal investment and the agreement she made prior to hiring all the new staff to try the program, social work cooperation was assured by the virtue of authority and initial expectations. Informal relationships developed within this small, close group, enhanced participation

of the social workers in developing and utilizing the new program. Thus, the informal communications network, reinforced the directive from the authority figure. This gave a strong base of support from which to begin to implement the new program.

Footnotes

[1]Harold Guetzkow, "Communication in Organizations," in *Handbook of Organizations*, ed. by J. March (Chicago: Rand McNally & Co., 1965), p. 50.

[2]Charles Perrow, "Analysis of Goals in Complex Organizations," in Readings in Modern Organizations, ed. by Amitai Etzioni (Englewood Cliffs, N.J.: Prentice-Hall, 1969).

[3]Three phases of innovation: "Initiation, implementation and institutionalization" (lecture of H. Weissman, May 6, 1974).

CHAPTER VI

IMPLEMENTATION OF PROGRAM

PART I

Recruitment

Once agreement was reached that the program should be implemented and my casework duties were relieved, my first priority was recruitment of volunteers. Meetings with the social service director and hospital administrator were held to discuss the guidelines for recruitment. We agreed to recruit volunteers during a one and a half month period and start the training program the first week in June, 1976. The volunteers would be asked to agree to work in the hospital 2 1/2 days per week for at least the three months of July, August and September. Those who wished to continue with the program would have the option to do so. It was agreed that we would run the pilot and try to assess how it operated before deciding if another or a modified program should be instituted.

Recruitment would be based on trying to attract bright, alert, interested people over the age of 60 years. Of major importance to the concept of the program was that this be a select group[1] and that each volunteer would participate in a training program to enable him or her to function in the specific role required.

To use an old social work principle, I started where the institution was, by meeting with the director of our own volunteers. She was most receptive to the idea of using a special group of volunteers in our department. We were able to work out the complexities of

special training and status for the older volunteers attached to our department, while agreeing that they relate to the volunteer office for insurance coverage, etc. The volunteer director easily saw that the program could benefit patients, volunteers, and would be seen as a plus for her department as well. The volunteer director discounted the concerns raised by the administrator regarding special status, free lunches for the month of training, etc., which other volunteers did not receive. Although the usual hospital volunteer was not over 60 years, the director of volunteers agreed to try to help recruit volunteers for our program. A new spirit of cooperation between the social service and volunteer departments had begun when the two new directors had both been appointed. Implementation of the program was an additional meeting ground for working together. Also within the hospital, I spoke to colleagues in other departments to request help in recruitment.

The next contact was made with the Westchester Volunteer Service Bureau, a clearinghouse for linking prospective volunteers to opportunities. The director of this agency came to speak to us regarding our need for volunteers. She was impressed with the program idea and agreed to actively seek volunteers for us. During the period of recruitment, not only did the V.S.B. speak with and screen several older people, but also ran an ad including request for help in our program.

Other than these two areas dealing specifically with volunteers, efforts at recruitment were devoted to contacting agencies and institutions whose values could be seen as congruent with those embodied in our proposed program. Concern for the need for extra service for senior citizens in hospitals, and the concern for utilizing older adults

in giving service were paramount. I contacted the senior center in the community. The social service director and I visited the White Plains Senior Center, met with the director and described our program. She agreed to discuss it with appropriate committees and to look for interested people.

I spoke before a general meeting of the Westchester Chapter of The American Association for Retired People to encourage interest. For the same reason, I also submitted an article to the publication of the County Office of the Aging. Contact with the person in charge of the Office of the Aging Information and Referral Service also produced leads on people who might be interested in such a program.

By contacting several colleges, I learned of some programs set up specifically for seniors and spoke at these. Numerous phone calls were made to churches and synagogues in the area. I discussed the programs with clergy, directors of senior programs or voluntary groups there, and received support and agreements to apprise membership. To many, I sent a copy of a statement about the program to include in their bulletins. (See Appendix B.) Contacts were made and descriptions also sent to women's clubs and a senior club for men. In an attempt to attract minority people, I spoke at the Community Action Program Senior Center and Nutrition sites, as well as with directors of these programs.

Calls and meetings led to positive community response to the program ideas and most often to genuine attempts to help recruit senior volunteers. There was generally a snowball effect from placing one call. Each person I spoke to would have suggestions for several other people interested in and having access to seniors. During this period of recruitment, I followed up on all names suggested and spread the

word that we in the social service department of the hospital were looking for qualified senior volunteers.

Social agencies were contacted, including those with special programs for the elderly. Senior centers and offices of aging in surrounding communities were also contacted.

In the geriatric committee meetings of the Mental Health Association, I reported on the end of the initiation phase of the proposed program and requested help with recruitment from the members.

Throughout this period of recruitment, the primary objective was to obtain a pool of interested senior citizens from which we could select 8-10 qualified people to participate in the pilot project. We tried to be clear on the duties and responsibilities of whomever became a counselor-assistant (the special volunteer), and on the nature of the pilot study, including need for evaluation, change, flexibility and the like.

A secondary objective in the recruitment procedures was to continue to develop awareness of the attempt being made at the hospital to provide a new service. I discussed our program at length with people in the community while asking for help in recruitment. This enabled us to obtain feedback on our ideas and further community support.

In looking at what was learned from the recruitment process, several propositions emerge. One of these, is that requests for help made in person are more effective than those made solely by phone or written word. In almost each group in which I spoke to the membership, there was active interest and people willing to apply. Provision was made in these cases for questions and answers regarding the program,

which allowed for testing out of the expectations and ambiance by the personal interchanges between speaker and potential counselor-assistants. The personal approach thus facilitated initial contacts later on. Those sources which allowed me to meet personally with the directors were also each successful in recruiting some people. The same principle of facilitating interchange operated here. Also at work was the fact that directors willing to take the time to meet with me were more interested at the outset in our program than those who felt they could only entertain a written memo. This former group was also more concerned about speaking with me as a representative of the hospital who might be interested in their programs as well.

Another proposition emerging was that if at least transportation and out of pocket expenses are not provided, a truly heterogeneous volunteer group will not be possible to obtain. This was clearly illustrated by my experience at the Community Action Program Senior Citizens Group. Interest was shown in the program, but I could recruit no one from the group because I could offer no tangible help in getting to the hospital and no monetary reward once there. The members of this group were vocal about the hardships they were already experiencing on fixed, low incomes, and clear about the fact that if some small income were involved and transportation easier, some would be interested in helping. Discussion with leaders at the Senior Housing projects revealed the same problem. It appears that for a volunteer program, like ours, which requests the large investment of time, energy and commitment, people who have above-average income are more likely to apply.

A third proposition was that if people heard about the program from more than one source there was extra impetus to call and request information or apply. Some people spoke of having heard me speak at the A.A.R.P. meeting and also learning from a friend, the newspaper or the senior center. One man, for example, had heard about the program as announced at one of his "Old Guard" meetings, but agreed to think about applying after also being approached by his clergyman.

Word of mouth recruiting is particularly effective in a selective program. A few of the people who applied to our program had heard of it through a friend. One person selected for the program happened to be sitting on a park bench with a friend and during the conversation, the program came up. Interest was aroused in the friend who came directly to discuss, apply for and be selected also to work in the program. Another example of "word of mouth" recruitment was a woman who learned of the program through an R.N. employed as utilization review coordinator in the hospital. In my discussions of the program with this staff member, I learned of her familiarity with people fitting our needs. I encouraged her to make direct contacts. A recently widowed woman was recruited this way. She was a former newspaper editor who was most capable and interesting. She brought a friend with her to also apply to the program.

Selection of Volunteers

During and after the recruitment phase, we also engaged actively in selection of volunteers. The director of social service and I had agreed upon specific selection criteria, as well as upon the selection

process. This was to assure that volunteers would be suitable for the program and in keeping with the goals of the social service department.

<u>Selection criteria</u>. People to be selected for the program had to be over 60 years, and show evidence of flexibility, warmth and ability to empathize. We were looking for people who had had some experience with illness and even death of a friend or family member. We decided that information as to the way in which the applicant had dealt with illness or trying circumstances would give an indication of how this person would be able to function in a hospital setting. What the person had done at home or at work in the past indicated possession of specific skills. How these could be applied to the present task had to be assessed. We wanted to learn why the applicant was interested in the program in order to make some assessment of motivation. The plan and arrangements that an applicant had for being available to work four hours on each of two days for a three month commitment was also explored to assess responsibility and reality of each person.

In general, how the applicant related during an interview and his or her awareness of feelings, illness and hospitals were all major determinants of his or her suitability for participation in the project.

<u>Selection process</u>. In every case, there was some type of initial telephone screening. This was done at the point where the interested first call was made. The Volunteer Service Bureau handled some, the hospital volunteer department handled others, and most, the social service director or I handled directly. Following this, an

appointment was made for an interview with the social service director and/or me, as program coordinator.

Some of the initial inquiries screened out people who were too young, too committed to other things to give two days/week, or not available during the time of the project. Within the first two weeks of the recruitment process, we received several inquiries from women of 55 years who were interested in the program. Each met the criteria of having interest in the program, experience with illness and the need to become meaningfully involved. They were experiencing a need for changing occupations either after becoming widowed or having the last child leave home. At this point, we had to arbitrarily limit those in the program to people over 60 years and suggested other alternatives for these women. It did suggest to us, however, that there is probably a sizable population of people, particularly women who, in their 50's would be interested and ready to help in a hospital setting.

Other than because of age, people screened out on the phone included some who seemed most interested, but who were going on extended vacations during the summer. Although they were willing to work before and after their vacations, because they were not available for the duration of the project, we could not suggest they be interviewed. Each of these was aware that if the program were to be repeated, they would be contacted. Each person with whom we spoke was given a clear description of the program, and commitment necessary. If the person were still interested, an interview would be scheduled for the applicant to be held with both the social service director and me.

After each applicant was interviewed, the social service director and I would discuss the applicant and come to a decision as to acceptability. To minimize anxiety, we tried to accept people to the program as soon after the interview as possible. Where we felt the person was not suitable, we dealt with this right away too. We had agreed that if either of us had serious reservations about an applicant, this person would not be accepted to the program.

A few people having come for the interview and acceptable to us were not sure themselves, about the program and either declined or asked to think it over. In this way, people either selected themselves out, or we made selections for the program until the very last day before the start of the training program.

Examples of selection process. An 82 year old man, Mr. J., came in for an interview and would have been completely acceptable for the program. He was retired from the textile business in which he had worked successfully for 50 years. He was married and had close associations of friends and men's club members. He had done and continued to do much volunteer work for the Lighthouse and was intrigued by the sound of our project. His experience and evidence of understanding led us to accept him immediately, but allowed him to decide against making such a physical and time-consuming commitment.

Another person interviewed and also seen as right for the program declined after much time and soul-searching. This was a 69-year-old recently widowed woman who had heard of the program by word of mouth and set up an appointment for herself and a friend. She was articulate, bright, warm and incisive, as befit the former women's page

editor of a local newspaper. Her experience with illness and loss was considerable, but she was really in the throes of mourning for her husband who had died only three months before. While she felt that participating in the program might be "good for her," she was able to discuss her ambivalence in light of our feeling that she would be an excellent counselor-assistant, but that perhaps she would need more time. Mrs. T. did call and decide she could not handle such a position at that time.

An example of someone we had to carefully screen out was Mrs. P., a 68-year-old woman who upon hearing of the program was most interested and enthusiastic. She came from some distance by use of complicated public transportation and yet felt sure she could handle the trip twice a week. She had managed the clerical staff at a company for many years, had retired, and was interested in trying something new. She was bright, vibrant and assured, but during her interview gave such evidence of denial, need to control and intolerance, that we felt she was unsuitable for the program. In this instance, we were able to delay the decision and I was able to check out other volunteer opportunities at a closer hospital before calling her. This allowed for our not including her in our program, but helping her to get involved in something more suitable by proximity and design.

Mr. G., a 75-year-old, soft-spoken retiring man, learned about our program from his doctor who suggested his involvement as an aid to his socialization. Although, not seen as a "danger" to patients as the previously mentioned woman, he was so isolated and shy, it was felt that he was not suitable for inclusion in the program. He, too, was helped to find a volunteer activity more in keeping with his own

style and personality.

In ways such as these, from the nearly 20 inquiries regarding the program, we finally arrived at a group of nine individuals selected to begin the training program.

Persons selected to become counselor assistants

A composite profile of the volunteer selected for the program would be a white, 67-year-old female, married and with two adult married children. She would have had a business background and now retired, but middle class. She would probably have had volunteer experience, some of which would even have been at a health setting. She had experienced illness, even hospitalization with a close relative. This volunteer came to the program because of interest in helping people in a meaningful way. She was interested in the idea of receiving training and felt she had ability to give companionship, understanding and support. In general, this volunteer wants to obtain a sense of satisfaction, stimulation and the reward of helping.

From the composite, perhaps we can look more closely at the breakdown of characteristics with the nine people selected, as obtained by answers to questionnaires administered at the first meeting of the group. (See Appendix C.) Of the nine, two were men. All the volunteers were white. There had been no black applicants. Six were Jewish, one Protestant and two Catholic in religion. The age ranged from 55-72 years. (We accepted one woman of 55 years because of special circumstances to be discussed later.) The average age was 66.7 years, mode 72 years with the median at 68 years. (See Figure I.)

Of the group, six were married and three widowed. There were no single or divorced persons in the group. Both men had living spouses and the age at which the three women were widowed ranged from one when she was 25 years to within the last three years.

Eight of the volunteers had at least one adult child. Five of the volunteers had two and two had one child each. One woman had had no children and one (the 55-year-old) had three. Only one volunteer never finished high school. The rest were high school graduates, generally with additional schooling. (See Figure II.)

Three of the volunteers had had previous hospital work experience. One of the men had been a hospital pharmacist, one of the women, a psychiatric nurse and another woman had done clerical work in a hospital. The other six had had some business experience, including bookkeeping, clerical work, managing, etc. Volunteer work experience included four who had had no previous volunteer experience. (This included both men.) Four of the group had volunteered previously in hospitals. Three had put several years in our own hospital in the past. One person was volunteering for another agency.

Only one of the volunteers had not had experience with hospitalization. Three had been hospitalized themselves and five had been involved with the hospitalization of a close relative.

The reasons that people gave for being interested in the program concerned helping people, learning and being in on something new. "I want to help people." "I am interested in doing something useful." "I have concern for the ill and elderly and here is a chance to do something about it." "I enjoy working with people." "I am interested in the training program and learning something new." "It is exciting

FIGURE I

AGE OF VOLUNTEERS

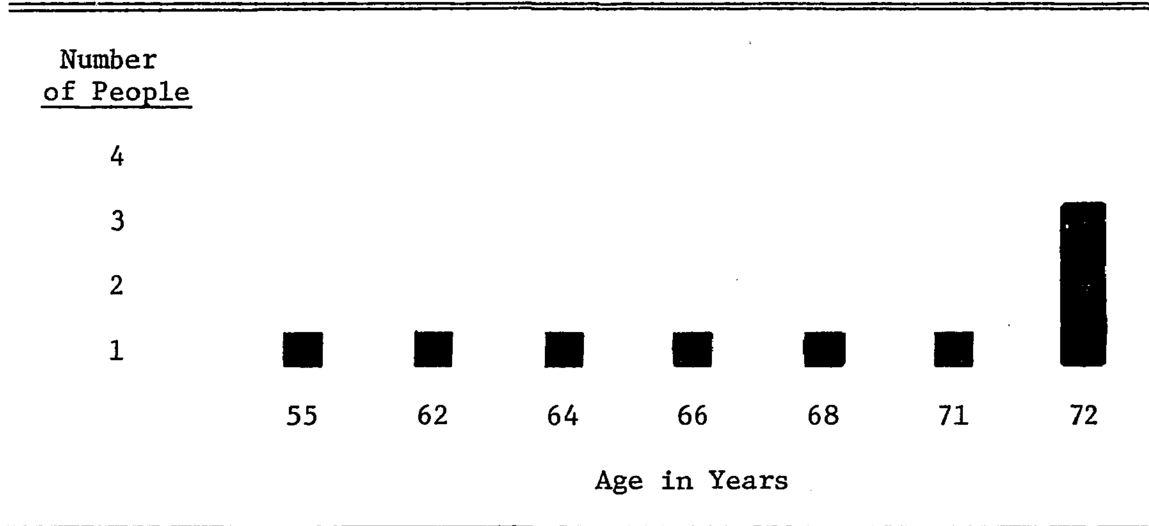
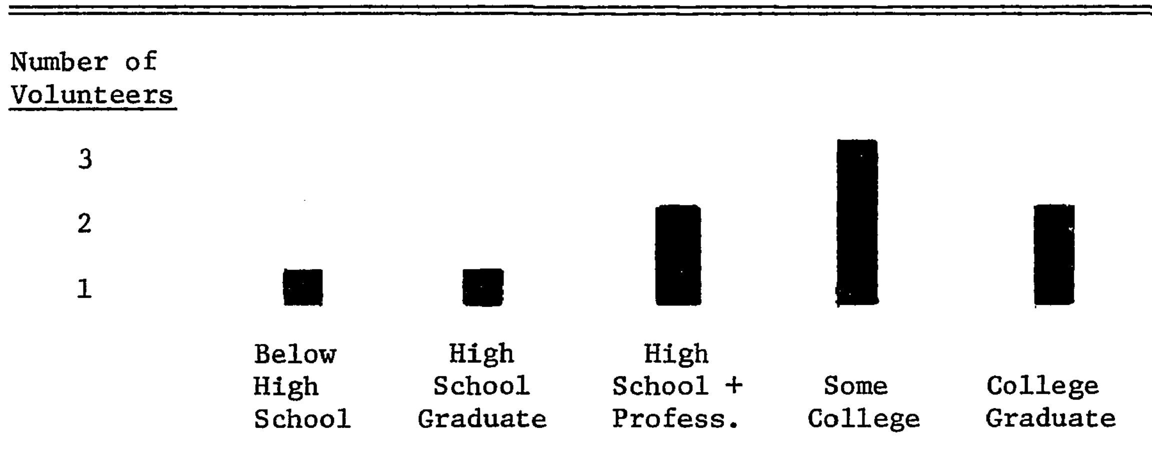


FIGURE II

EDUCATION LEVELS



to be involved with something new--an untried project."

All the volunteers felt that they could give comfort, compassion, time, friendship and support to hospital patients. They hoped to get the reward of satisfaction in helping and being useful, as well as associating with others. For the most recently retired, there was also an element of trying to retain a commitment to a job.

The selection of people suitable for the program is felt to be of utmost importance. Those people accepted to the program had the specific characteristics seen as necessary to functioning as counselor-assistants. Specific personality traits and styles became apparent, and were important in determing ways of helping them to fulfill the role. Two of the selected volunteers dropped out before the end of the training period. That these two might not continue was apparent at the outset, as can be seen in the following short descriptions of each volunteer.

Descriptions of volunteers

R.K. R. is a 55-year-old white, Jewish woman who is married to a dentist and has two married children and one unmarried but living away from home. R. heard of the program through the hospital volunteer department, and although below the age requirement, was accepted to the program because of special circumstances. She is a college graduate who has always been interested in social work. Years ago she had volunteered in the hospital clinic doing financial screenings and had later volunteered in the hospital coffee shop when social service was not using volunteers. Because of this interest, the program was very

special to her. Before having children, she had done office work and while her children were growing up, she had held administrative positions in P.T.A.'s and other voluntary organizations.

R. is an attractive, bright, decisive individual who can empathize while maintaining objectivity. She is warm and sincere while being very calm and efficient. R. had had personal experience with illness when her husband had suffered a heart attack and then when a son had been seriously ill. She had been able to cope with these periods as well as having helped an older aunt who had been chronically ill and in need of care for a long time. Particularly when speaking of the last experience, R.'s understanding of the elderly was apparent. She also enjoys older people. R. is a very special person, combining all of the qualities we were seeking in a volunteer. Because of these and her great interest in social work, she seemed ideal for the program. We agreed to accept her despite her lack of the age requirement.

F.N. F.N. is a 72-year-old white, Protestant, married woman. She retired seven years ago, after having been a psychiatric nurse at a large private training center in the area. F. remembers being in on the changes taking place in psychiatry and is interested in change and innovation. She was particularly intrigued by the fact that our program would be a pilot project. F. is married but has no children. Her husband is also a nurse and had been in charge of one of the units at our hospital for many years. At present he is retired and at home, suffering from some chronic ailments.

F. is a prim, neat, concerned individual. Although she suffers from much anxiety about her performance, she relates well to people and

seemed to be very capable of meeting needs of patients. F. is very active at the senior center and learned of our program through the director there. She is proud of her advanced years and senior status. She has spoken of having a period of depression following her retirement and saw participation in the program as being another step in involvement and return to better spirits. Her background, interest and apparent ability led to her acceptance for the program.

V.B. V. is a 62-year-old white, Catholic woman. She is married and living with husband and divorced daughter and two grandchildren. During the course of the project, her daughter remarried and moved out with the grandchildren. V. was a high school graduate who had held hostess and then managerial positions. She had retired about ten years ago and since then had heavy volunteer commitments. She had done interviewing for the senior employment committee here and gave one day a week at the other hospital in the area in the dietary department.

V. is a small, slim, frenetic woman who appeared energetic and willing. Although she was anxious and driven, she exhibited ability to empathize and engender confidence. V. had had much personal experience with illness and death. She had helped a 90-year-old mother retain her independence although blind and ill, until having to place her in a nursing home for care just before she died. She had helped an older aunt also in ways which showed her respect for and ability to allow independence. V. had seen the ad from the Volunteer Service Bureau, in the paper regarding the program and had called there. They felt she was suitable and referred her to us. V.'s skills with people,

apparent values about the elderly and great interest, led to her acceptance in the program.

L.W. L.W. is a white, Jewish, 68-year-old woman. She is an attractive, well-turned out woman with a trace of accent from Massachusetts where she was from originally. L. had done statistical work in the past, but when raising her two sons, turned to a variety of volunteer work. She had worked as an escort at our hospital for three years and left when she had been ill about six months prior to the program.

L. is a member of the senior center and learned of our program from the center director. Her husband is president of a retired men's club which had been approached during recruitment. Although he was not interested in working himself, he was able to encourage her participation.

L. is eager to be active and interested in helping people. Her experience with illness and surgery, herself and as an escort, taking patients around in the hospital, gave her ideas about ways people in hospitals could use help. L. is bright, cheerful and able to be unobtrusive and helpful at the same time.

L.G. L.G. is a dark-haired, round-faced, 64-year-old white, Jewish woman. She had been a widow for many years and had always worked to support herself and her daughter. The daughter is now married and living in California with her husband and five children. L.G. came to the hospital volunteer department to ask for information about the program, as she had learned of it while sitting in the park with one of the prospective volunteers, L.W. We agreed to interview

her right away, as the training program was to begin on the following Monday.

L.G. is a charming, articulate and dramatic woman who presents a picture of competence and ability. She can put people at ease and is in touch with her own and the feelings of others. The strong and easy manner she presents, belies the tremendous need for approval and appreciation she seeks, but was seen to be most useful in her participation in the program.

L.G. is conscious of herself as an intelligent, working woman. She had been a bookkeeper and manager of variety of business and was now unemployed because she had been replaced after undergoing a hysterectomy several months prior. She was supported by unemployment compensation and concerned about money. While still looking for employment, she was interested in our program primarily because it sounded "meaningful." She was impressed with the need for a training program and was excited about being in a program that not everyone could do. It was a first foray into volunteer work.

M.M. M.M. is a cherubic, cheerful, 72-year-old white, Catholic widow. She lives with daughter and son-in-law in lower Connecticut and heard of the program through her daughter who is one of the head nurses in the hospital. M. is a quiet, unsophisticated woman who was interested in talking to people. She had been to high school and business school and had worked for a variety of companies as well as in a hospital doing clerical work, before her retirement one year ago. M.M. had experienced her husband's being in and out of hospitals for heart problems before he died. She grew to know the

anguish this caused. Through this experience as well as her daughter's dedication, M.M. was well aware of hospital work.

Since her retirement, M. had been doing more things at home. Although a member of the senior center near her, she was not very active. Both M. and her daughter were eager for her to try the program, both to give her a meaningful outside role and to give help to others.

M. appeared much less sophisticated and insightful than the others, but had a natural warmth and interest that seemed to be productive. Her transportation arrangements in coming to the hospital were complicated and dependent upon her children, but we decided to have her try to participate in the program.

A.Y. A.Y. is a 72-year-old, white, Jewish male. He had been a hospital pharmacist for the past 18 years. He is now on unemployment because of the recent closing of his hospital. A. had heard me speak at a program for seniors given at one of the colleges.

A. lives with his wife and 43-year-old bachelor son, also a pharmacist. A daughter is married and living on Long Island. A. has never been hospitalized, but had experienced the hospital care and long rehabilitation involved for his daughter following a car accident.

A. had never volunteered before, and seemed eager to view this volunteer work as a job commitment. A. gives an impression of knowledge and authority, but has a soft quality which allows him to relate easily. He has some need to deny feelings, but appeared able to learn and to become sensitive to the needs of others. He felt that his experience in hospitals could be used in working at our facility,

and was not concerned that he might be the only male participant in the program.

R.L. R. is a 72-year-old, white, Jewish man who together with his wife lives in the home of one of two daughters. R. had had some college education and before the war owned his own clothing business. At present he does some free-lance bookkeeping.

R. is a small, cheery individual, who enjoys making others happy. He saw himself as being able to joke people out of depressions, but was open to the suggestion that he could learn other ways of helping people feel better.

R. had heard of the program when I called him directly to describe it. His name had been given to me by a representative of the Office of Aging, Information and Referral Service, who had spoken to a group of which R. was a member. Since he had offered to volunteer, I contacted him to suggest our program. R. was most interested in our project and felt that even with his part-time work he could commit himself to giving two days per week to the program.

Experience in a hospital was not new to R. as he had been hospitalized with a heart attack. He remembers the depression he suffered during that period, as well as how important the interest of others was to him.

R. was accepted to be a participant in the program, although we were aware from the outset that because of his heart condition, his doctor might prohibit such activity.

P.T. P.T. is a tall, slim, stylishly dressed 66-year-old white, Jewish woman. P. has been a widow for three years and lives

alone. She has a married daughter and grandchildren in Connecticut, with whom she is close, and a son, married and living in Oregon.

P. heard of the program through her friend and came together to the initial interview. Although the friend (recently widowed newspaper editor described earlier) did not join the program, P. was interested. She did harbor some reservations about the time commitment.

P. had two years of business school following her high school graduation and had worked for a short time before marriage. She did work as a receptionist and typist in her husband's dental office, part-time.

P. had experienced the drawn-out battle her husband had with leukemia and was able to discuss the difficulties of the chronic illness and subsequent mourning process involved with her husband's death. She had also struggled with the tragedy of a car accident in which her daughter-in-law suffered brain damage. Within the last year and a half, P. has been giving a day each week at the Association for Retarded Children. She has found this most rewarding both because she is being helpful and the tangible signs of agency appreciation in the form of parking and free lunches.

She was intrigued by our program and felt she had something to offer in ability to listen to people and be tolerant. She presented a picture of being bright, capable, efficient and willing to give of herself. She was accepted in the program although her agreement to come was on a trial basis in case the time commitment became too burdensome.

Preparation of Social Work Staff

As stated earlier, in this particular situation, the two new full-time M.S.W.'s were well aware when they accepted their positions that there would be some program utilizing older volunteers. The one full-time and one half-time secretary were also aware of the program, even prior to my joining the staff. They had been aware of the planning I had been involved in with the previous social service director, and were supportive, personally, throughout all the changes, new personnel, and eventual hospital commitment to go ahead with the program.

Because of the small, close nature of the department, the preparation for program implementation was done generally through informal discussions. Initially discussion was on how such volunteers could be helpful to patients and even to the social workers. Suggestions from staff were built into tasks later required for the counselor-assistants. Because of the personal relationship I had with the staff, there was much encouragement to produce the program and willingness to participate even with some of the extra tasks this would involve.

Before the training program, staff members were kept informed of the people being selected for the program. They were encouraged to join in the free lunch with the volunteers during the four weeks of training in order to feel part of the program and make the volunteers feel part of the department. Following such meetings, their perceptions and suggestions were used in working with individual volunteers. Throughout the planning and initiation phase the total support of the social service director led to acceptance and participation in the program by total staff. Some formal meetings were held to inform staff

about specifics and obtain feedback on these. The importance of differentiating between tasks appropriate for counselor-assistants, and those reserved only for social workers were discussed at length. The research instruments were discussed with the social workers and some questions added or deleted because of their input.

Attempts were also made to introduce our secretaries to the new volunteers, and to obtain suggestions from them as well. In asking for extra work from the secretaries in typing and xeroxing a myriad of necessary materials, it was important that they understand the program and feel a part of the excitement of developing something new.

As program coordinator, I was available to hear complaints, accept occurrences of resistances and encourage participation of the social work staff. Acceptance of negative feelings that had to occur because of the pressure of high work loads and now additional responsibility, as well as giving concrete suggestions for short cuts was an important element in the preparation of the social work staff.

Specific information on how to use the new volunteers, how to choose patients for volunteers to see and ways to supervise volunteers was a basic responsibility of mine as program coordinator. These areas were discussed at several staff meetings and informally as the needs came up. Each social worker had to modify some of the initial suggestions to fit her own style as well as that of the counselor-assistant with whom she was working.

There were some problems in adequately preparing replacement social work staff people who came in to take over during my two months leave of absence and summer vacation periods taken by each social worker. Three social workers who had formerly worked at the hospital

are available to the department to come in on a part-time basis to fill in. They are called in as needed and fill in as they are available. This is a tremendous help to the department in caseload coverage, yet preparation of such workers for the new program was more difficult. There was less time available to help each understand the nature of what we were doing and lack of clarity on how to use the volunteers was a problem. Because of their personal commitments outside of the job, no one person was able to stay for a long enough period to become very involved. Although not a major stumbling block, this caused some discontinuity and confusion for the counselor-assistants.

Preparation of Hospital Staff

After the administration had agreed to implementing the program, I informally approached physicians for approval, and our social service director spoke to the physicians governing committee to obtain formal permission and approval. There was general verbal support, and concerns about selection and training of volunteers were dealt with.

Once the actual date for implementation of the program was set, I stepped up the informal discussions I was having with staff people I worked with. The other social workers were asked to discuss the program with the nurses and aides on their floors. They were to inform them of the relationship of the counselor-assistant to our department and the function they would be serving on the units. They were to apprise nursing staff of dates training would begin and the nature of the training. Suggestions given by the nurses for best times for patients to be seen, and ways to help patients on their units were

noted and incorporated in the training. Formal communication was through contact with the director of nursing and permission obtained to speak about the program at a regular head nurses meeting.

The social service director spoke about the program at a department heads' meeting, so the other hospital departments would be aware of the new program. I spoke personally with people social service works with closely, like the patient representative, members of the home care department, members of the utilization review committee, and physical therapists. Both via channels of authority and through informal talks with hospital staff, people were prepared to have the implementation of the new program.

Further hospital staff preparation and cooperation was obtained by involving various staff people in the training program. This was based on the social work principle that greater involvement leads to greater participation and cooperation, as well as on the educational principle that people doing specific roles can explain them to others.

Footnotes

[1] Verne Weed and William H. Denham, "Toward More Effective Use of the Non-Professional Worker: A Recent Experiment," *Social Work*, VI: 4 (October, 1961), 32.

CHAPTER VII

IMPLEMENTATION OF PROGRAM

PART II

Training Program

The need for a training program

Training was seen as an inherent part of the implementation of the program. The following will discuss basic reasons for this.

Linkage function. Training was a necessary part of the overall program design. The project goals of trying to decrease isolation, fear, discontinuity and disorientation in the older hospital patient were dependent upon setting up a specific program utilizing trained older volunteers. As we discussed, institutions and primary groups operate at some middle point of social distance and breakdown occurs when they are either too close or too distant. Therefore, in assessing needs in the hospital, we decided that distances between patient and hospital and community were too great and an extra link could be tried. The link utilized in this program would be the "trained, semi-primary group member" who could be used to provide a different and extra service needed by the older hospital patient.

The "semi-primary group member" was obtained via recruitment and careful selection. This person, although not of the same family as the patient, would share similar generational level, life experience and be interested in a relaxed, friendly visiting kind of relationship.

The senior person selected because of his special attributes and values, would then have to learn skills necessary in helping hospital patients. He or she would then be able to provide the necessary linkage by being, as stated, a part of the primary group, as well as by virtue of volunteer status and special training, a part of the institution. His characteristics of both primary group and "bureaucracy" would allow him or her to span both and help link one to the other. Having a training program was thus essential to the nature of the project and probably made the difference between any volunteer with useful attributes and one who could link institution and community to patient and family.

Support. A training phase was important for secondary reasons as well. In working in an atmosphere where illness, disability and even death prevail, much support is needed. No matter how professional or sophisticated, experienced or knowing, every person is subject to bouts of anxiety, hopelessness and even revulsion. Before asking people to give of their time and energy in the hospital setting, it was important to help them become conscious of such feelings and help them to deal with these.

Socialization. The training was necessary to socialize the counselor-assistant into the social service department. It was important to help them become acquainted with social service and to differentiate between their tasks and those of the professional social worker. At the same time, it was necessary to provide an identity with the hospital and the department.

Group solidarity. The training would also be expected to provide group solidarity and cohesion. Although disparate people, they all had certain attributes in common and were drawn to this same heavy volunteer commitment. Training was seen as a medium for peer support. It would allow these people to form a group, separate and distinct from other volunteers. It would help them get to know each other and enjoy the association. Training was planned to give not only emotional support, but also to add to the satisfactions obtained by our volunteers.

Personal development. The people choosing to help in this program were people who welcomed the idea of learning. That we were providing such training was one of the "drawing cards" of our program. It allowed for the real feeling that not just anyone would be able to become a counselor-assistant. Instead, it would take some input from our department and work on the part of the volunteer. Although productive of some anxiety, it added excitement and promise of growth and ultimate identification as a counselor-assistant.

Role identification. The training period allowed for people to learn and become comfortable in their new role. It gave some measure of security in handling new tasks. It was set up not only to impart knowledge but to help in developing skills in interviewing, listening and supporting. It was to be an arena where techniques could be tried out, discussed and modified. By the use of a variety of modalities in areas pertinent to tasks given the counselor-assistant, the training program was set up to impart necessary skills, develop useful attitudes and contribute to group solidarity.

Theory involved in developing the training program

Factors intrinsic and extrinsic to training. In developing any curriculum whether a full-blown sequence of courses for the professional, or a modest training program for paraprofessionals, several factors have to be taken into account. Charles Guzzetta speaks of the extrinsic and intrinsic factors.[1] The former are those which are "apart from the program itself, but have an impact on the program design and operation." The latter "intrinsic factors" are those that are "integral to the program design itself and are reflected directly in it."[2] In all such factors the structural, ideological and political elements have to be considered.[3]

Since the goal of this training program is to produce counselor-assistants[4] to work directly with hospital patients, development of a training curriculum had to take into account various extrinsic factors. In society today, there is increasing pressure for second career training, and continued adult learning as an outgrowth of longer and healthier life-spans and earlier retirement. Training people to fulfill a new role within the hospital context is in keeping with this new emphasis. Technological changes have helped to bring about better health, but have led to increasingly fragmented and depersonalized health care delivery. This extrinsic factor has created a gap in service, particularly for the older person who has fewer supports to help him cope with the increasingly mechanized world. This broadens the charge of in-hospital training to include a specialized group to deal with psychological and social problems of older people. How the counselor-assistant relates to the other disciplines within the

hospital was another extrinsic factor to consider. Since this volunteer acts in conjunction with the social service department, what he learns is influenced by the social work profession, but his special role must be clear to him and clarified to the other hospital personnel. The fact that he is being trained to work in a host institution whose primary concern is medical, is another extrinsic constraint on curriculum.

Intrinsic in the training program is the ideology that older patients are entitled to the best possible care and service and to insure this, a trained "semi-peer" group can contribute to this goal. A cadre of such volunteers would have to be cast in a para-social work ideological mold. Curriculum would have to be based on giving them tools to make them more expert in dealing with the social problems of older patients and because of the nature of what they bring, they can become a strong force to advocate for better service for their peers. In this particular program, because of the ideological and even minimal financial support given by the hospital, accountability for training would be divided between hospital administration, hospital social service, and in small part with the geriatric committee of MHA where the idea was conceived.

Another intrinsic factor in the training was the competence of the students and staff. Since the selection process was to insure bright, competent senior citizens to receive special training, and have lecturers from specialized areas, there was some attempt to control this. The ability of the staff to effectively supervise the new volunteers was an unknown that the initial attempt at formulating this program could document further. The relationship between the trained

volunteers and the staff was an important element to consider. The possibility of the trainees overidentifying with either the older patients of the social worker and the various ramifications of teaching and then utilizing older persons in the hospital context had to be taken into account.

Intrinsic structural elements are related to ideological and political considerations. Because the program was to train a specific group (older adults), and had to take place within a specific political configuration, space, size, time and sessions were all determined accordingly. The program was to be small; set up to train between eight and ten older adults. It was decided to hold it on two days each week with four hours (10 a.m. to 2 p.m.) including lunch on each day. This was set up so as to get a lot in on days on which the volunteer came, but not to be excessive as to be too fatiguing. Because its legitimation was through social service, space given to lecture, supervision, seminars, etc., would be that of social service, or that requested by social service. Hospital support allowed field training to occur throughout the hospital and some instructional help from other hospital personnel.

Factors in teaching adults. Inherent in this training program was familiarity with a theory of how adults learn. Malcolm Knowles set forth a useful theory of andragogy or adult learning[5] which was intrinsic to this course of training. He carefully states that adults are essentially self-directed, interested in experience and analyzing that experience. The suggestion that adults are ready to learn things that they need to know comes with the recommendation for direct

experience with people as a prelude to learning methods or techniques. Curriculum for the training program was designed, therefore, to have volunteers see patients by their third meeting.

Knowles speaks in his article,[6] of the major role played by climate in adult learning. This climate includes breathing the emotional air of informality, mutual respect, openness and collaboration rather than competition. Such ambiance seemed particularly important in designing a training program for adults to do a specific task as volunteers. Always kept in awareness was the notion of learning and growth leading to satisfaction, but coupled with the reality that this was learning for a specific role that the learners would be then asked to perform.

Physical comfort, while always helpful in learning, was seen as something most important in a course designed for older adults. In setting up the program, great efforts were made to insure this. Given social service offices that were already carrying doubled usages, I had to seek other quarters in the hospital in which to base our training. Conference rooms in the newly built wings of the hospital were checked and after deciding upon the largest, airiest room and negotiating for its use, lengthy attempts to get it furnished had to begin. A small detail like the type of chairs was highlighted by the intrinsic nature of this group. We could not settle for the bridge chairs offered for a course for older adults. Instead, comfortable, substantial chairs were located and finally appropriated for our use, after careful work in supporting and interpreting to our purchasing department.

Curriculum content was designed with the outcome role in mind.

If the senior volunteers were to provide empathetic, warm relationship to older patients in the hospital, give help in linking to community resources, family and hospital personnel and gather data on the specific needs of older hospital patients, they had to get specific content in their training. Areas to be covered had to include sensitization to the hospital patient, interviewing techniques, tools with which to deal with hospital and community personnel, information on resources available to senior citizens, practice in record keeping and using supervision and a format for data collection. The process of designing a format to impart such knowledge and experience had to be based on some sequence of steps in order to integrate the parts into some coherent whole.[7] That the learner should be an active participant in the process and practice new skills to acquire facility is well-documented.[8] That the learning occurs in a variety of ways for various people is also known. Thus, the training program was set up to provide a number of modalities for imparting the proposed content. Lectures, discussions, guest speakers, field experience, films and informal talks with staff were all planned in developing the training course.

Such curriculum and format followed from the other intrinsic factors in such a training program. We were dealing ideologically with an attempt to provide better service, politically with the use of a specific population group to do this and the concomitant structural and androgogical arenas in which such a training program could operate.

Differentiating between professional social workers and non-professional counselor-assistants

There are running battles in agencies and much discussion in the literature on the use of professionals versus the use of the non-professional. Task differentiation in social work agencies is often difficult and the cause of great strain. There are warnings of role confusion and reports replete with the woes of disappointment inherent in placing non-professionals side by side with professionals. In developing a program to train a group of people to volunteer on an extensive basis in the social work department, this problem area had to be considered.

There are some useful conceptualizations to help to guide thinking in this area. William Richan speaks of key variables being "client vulnerability" and "worker autonomy."[9] He suggests that the professional worker deals with highly vulnerable clients and a high degree of autonomy, necessitating the full range of professional education. A specialist with technical education can work also with a highly vulnerable group but his tasks are more routinized. A sub-professional does tasks similar to the professional, but with less vulnerable clients, and with a plan of eventually receiving further training. An aide in Richan's terms has limited responsibility with the least vulnerable clientele.[10]

Florence Hollis discusses a variety of techniques which are used in achieving casework goals in order of their complexity.[11] Tasks could be differentiated on the basis of technique allowing least complex to be carried out by a trained volunteer, and most complex, by educated professional. "Sustaining procedures" of demonstrating

interest and desire to help, "direct influence" of offering suggestions and advice and "catharsis" or ventilation of inner conflicts and feelings could be modalities at less than professional levels of work. While reflective consideration of "current person-situation configuration," "dynamics of response patterns," or "development of clients response patterns" all need a higher degree of worker knowledge.

Another way to look at work differentials involves Fine and Wiley's description of functional job analysis.[12] They try to break down the social work job into tasks or "fundamental units of work." Looking at what a worker needs to do in relation to data, people and things and the complexity involved allows analysis of the task. Whether tasks are prescribed or discretionary relates to who can do them. Standards against which performance can be assessed as being "descriptive" (subjective and non-specific) or "numerical" (objective performance criteria)[13] are also important in differentiating between whether a professional or non-professional should handle them.

Barker and Briggs devote a book to the differential use of social work manpower.[14] They define this as "the social work organizations allocation of its functions to the organization members who are considered most capable of fulfilling them efficiently."[15] How do we know the answer to such a demand? They suggest implementation of the concept of "episode of service," or a "cluster of activities that go together to achieve a social work organization's specified goal."[16] The emphasis of the social worker, they suggest, could be on assessing need for concrete services, rather than on fulfillment of that need. "Decisions about when such a service is needed do not have to be made by the individual who provides the service."[17] Instead, these could

be separate activities all leading to the "episode of service" for a client. Barker and Briggs conclude that a team approach is most useful in providing help to a client. Work they feel a non-professional can be expected to do includes provision of concrete services, meeting with associates of patients, gathering of information and finding gaps in service to the patient.[18] Such non-professionals do not make decisions regarding goals of service, but rather carry out the technical tasks which require no further judgments.

In some of his work, Harold Lewis carries out even further the emerging definition of levels of practice by analyzing skill.[19] He separates skill into the four dimensions of "values, knowledge, style and process," and allows for varying levels of mastery of each to define work of preprofessionals through advanced professionals. While he discusses this from the point of view of social work practitioners, it is useful in considering roles and expectations of our group of trained volunteers. We can view them in this conceptualization as being a part of the technician or preprofessional level of skill mastery. Their values, in the form of "commands" and knowledge in the form of "directives," rather than being expected to have ability to operate on "ethical imperatives" and "theories" was built into the training design.

Throughout the variety of authors giving thought to the question of differential use of manpower, levels of practice, etc., several themes emerge. The area of judgment, particularly judgments based always on incomplete information, are seen best left reserved to workers with greatest training. Complexity of goal is another broad criteria for need for professional intervention. That some tasks--

concrete, sustaining, routinized--can easily be left to non-professionals or volunteers seemed agreed upon as well. Some combination of levels of skill has been suggested. Precedent is set for the involvement of more than one person with a patient or client, depending upon the areas of expertise of the former with the needs and goals of the latter. It is in actually differentiating and allocating tasks that reality causes the conceptualizations to become a bit fuzzy, and overlap occurs.

In defining the role of the counselor-assistant for this program, we tried to avoid the "scylla" of training people to be pretenders to the social work role, or the "Charybdis" of being messengers for the social work gods!

I found it useful to consider a conceptualization of thought processes given in a book by Benjamin Bloom.[20] He sees thought as occurring on a scale of complexity, with the six steps being "knowledge," "comprehension," "application," "analysis," "synthesis," and "evaluation." In designing the training program for our volunteers we could attempt to bring in knowledge which could be learned and comprehended. This knowledge of patients, hospital, community could be applied case by case. However, ability to analyze, synthesize and evaluate would be solely in the province of the professional social worker. The counselor-assistant would learn how to form a relationship with the patient, how to listen to obtain information, how to show empathy and understanding, as well as specifics about resources, regulations and routines. When, to whom and how much to employ such knowledge would rest on the analysis of the situation by the social worker, the synthesis of information obtained from a variety of sources,

by the social worker, and the ultimate evaluation of the situation and goal, solely by the social worker.[21] In this way the distinction becomes clearer as to what the newly trained counselor-assistant should be able to do.

Such a volunteer was seen to provide a unique contribution because of who he is and the time he was willing to give, as well as what he would gain from the training program. From the latter it was planned, that the volunteer develop some early skills in areas in the social work armamentorium, as well as attitudes conducive to working in the hospital. Of great importance was the transmission of the knowledge of who he is not and how to use his skills under social work direction.

The design of the training program

Using the theory just discussed, the author designed the training program in order to:

1. Impart concrete knowledge of:

   a. Hospital orientation
   b. Routines
   c. Community resources
   d. Nursing homes.

2. Create more skilled behaviors:

   a. Interviewing - empathetic listening
      indicating concern
      obtaining information
      maintaining confidentiality

   b. Recording - information on patients
      research data sheets

   c. Ability to explain role.

3. Encourage attitudes of:

   a. Acceptance
   b. Understanding
   c. Wish to help.

4. Form group cohesion:

   a. Mutual support and concern
   b. Provide continuity
   c. Provide satisfaction and esteem for trainee.

For each area, specific teaching modalities were to be employed:

1. Building knowledge:

   a. Lectures
   b. Tours
   c. Reading materials
   d. Resource Manual[22]
   e. Seminars on resources.

2. Imparting skilled behaviors:

   a. Role-playing
   b. Patient experience and supervision
   c. Discussions of specific cases
   d. Discussion of imagined problems.

3. Developing attitudes:

   a. Setting tone employing social work values
   b. Sharing own experiences of illness, hospitalizations, loss
   c. Role-playing
   d. Films.

4. Forming group cohesion:

   a. Meeting together and learning about each other
   b. Lunches together
   c. Sharing common experiences
   d. Identifying common needs and past experiences
   e. Graduation ceremony.

Based on the foregoing outline, a formal "lesson plan" was devised. It is included in the appendix to give the general format of the planned four-week training program. (See Appendix E.)

The overall outline in the plan was followed completely, but specifics had to be dealt with in a flexible manner. Depending upon interest, some areas were given more time than planned. Experience seeing patients and discussion following this involved greater proportion of allotted time than had been planned. Because it aroused anxiety, while stimulating interest, such discussions were a good modality to deal with feelings and attitudes as well as specifics in techniques and knowledge.

Technical complications made some changes necessary. In one instance, a video-tape had been planned to introduce the discussion of "reminiscence." Although great planning had gone into obtaining the tape and having the hospital order the necessary equipment, at the last minute it was learned that the equipment was incorrect and the tape could not be used. Throughout the training, there was never a feeling of having too much time to fill. Even in such an instance where the planned activity was impossible, there was such a vast amount of material to go over, there was never a problem in filling the allotted time.

The trainees showed a very high level of motivation and participation. They were, as a group, able to share experiences and speak of feelings quite openly. They tried to use new ideas and concepts and were themselves excited and exhilarated by the learning process. There was much give and take in discussions and a spirit of cooperation appeared to flourish. Although training was planned to last from 10 a.m.

to 2 p.m., the time had to be extended almost an hour each time. Any concerns about participant fatigue, inability to sustain concentration or waning interest were proved unfounded early in the training.

Handbook and Resource Book

Also to be found in the appendix are copies of the "Handbook for Counselor-Assistants" and the inside pages of the "Resource Book" that were distributed to each counselor-assistant. The Handbook (see Appendix F) was developed solely for this program and was an attempt to define more clearly the role and expectations for the senior volunteers. The Resource Book is a compilation of several sources that give information on community resources within close proximity of the hospital. The actual book which was designed by the author was a hardcover, three-holed looseleaf, which had pockets inside each cover and titled separators between information on each type of resource. The actual resources needed, were able to be found with ease and telephone numbers, addresses and some descriptive material all readily apparent. Having the looseleaf allowed extra pages to be added. When new information was received, it could easily be put into the correct section. The data sheets that the counselor-assistants were asked to complete were all given with holes already punched to allow them to be carried neatly, also in the looseleaf. In this way, each volunteer had his sheets readily accessible for him to mark and hold until handing them in to me. When designing this book, it was felt strongly that the covers would be hard to provide a ready writing surface. Because the counselor-assistant was being asked to see patients in their rooms and

would sometimes have to write balancing on his knees, carrying a book that could be used to lean on when writing seemed appropriate. The hospital administrator agreed to this suggestion when shown the sample and covered the cost of producing twelve such books.

Each book was personalized and presented to the counselor-assistants near the end of the training phase. They each felt that this compilation of resources and place to keep papers was most useful. The secondary gain of this item was both as a "crutch" to hold and a kind of prestigious symbol of special status for each counselor-assistant.

Drop-outs from program during training phase

Of the nine volunteers who began in the training program together, seven remained to graduate and begin working. The two who dropped out, were the two who when accepted gave some suggestion of the possibility of not continuing.

R.L., the man described earlier with a heart condition, did see his doctor and was told that participation in the program might be injurious. Although disappointed, R. had to drop out of the program after the second training session. R. was missed because he was a pleasant and cheery individual. He was also missed because the volunteers had already begun to form a group as well as the fact that R. was one of only two men.

The other "program drop-out" was P.T., who from the beginning was late frequently, and complained most vociferously about the very real parking problem in coming to the hospital. P. was ambivalent

from the beginning about coming, and although she attended three of the four weeks, she did so with difficulty. P. related more to me than to the other counselor-assistants. She was open about her feelings that coming was difficult and that she was treated so much more specially when volunteering only one day a week at A.R.C. I encouraged her participation, but finally suggested that if it were too difficult, perhaps she should reconsider her commitment. P.T. decided the work at the hospital was just too time-consuming for what she was getting and left the program.

Evaluation of the training program

As part of the last session of the training program, the participants were asked formally to evaluate their experience. Each participant was asked to write answers to the eight questions. These were collected to be tabulated and all then contributed to an open exchange of views on how the training had gone.

There was generally good feeling about the training and their participation in it. Several of the volunteers would have liked further time for the formal training to continue. Others felt they were ready to plunge in and with the help of continued group meetings would feel secure. Mention was made of perhaps, too much time spent on personal experience, yet several felt hearing of these enhanced their own learning and understanding. The suggestion was made that perhaps one day could be spent going around with the individual social workers to see more clearly what they were engaged in. It was agreed that they would have the next week off as it contained a holiday and that on the

day they returned, they would spend the morning with the social worker as requested. In the afternoon of that day the graduation ceremony was planned.

Results of the written evaluation are as follows:

1. Did you enjoy the training program? All seven participants responded yes to this question. Reasons given included several who said, "It was informative and instructive." Other responses included, "I met new faces, and got new ideas," "It was satisfying," "It helped show me how I could help patients," "I was impressed with your thoughtful preparation for this course."

2. Do you feel that you learned things that were helpful in doing the job required? If so, list a few. All the volunteers answered yes and their lists included seven who mentioned learning about resources and agencies as of major import. Four spoke of learning about how to approach and understand patients and three mentioned hospital routines as being important things to have learned.

3. Do you feel that enough time was spent on each topic? In what area would you have liked more time? Three people felt there was enough time. Four would have liked more time to be spent on community resources, including the financial aids.

4. Do you feel there were areas not covered at all which would have been useful? What? Five volunteers felt coverage had been adequate, although two of these suggested that further questions might arise as they worked in the program. Two felt that some areas were not touched upon including alcoholism and drugs and senility.

5. Which learning modality did you find most helpful? Why? Respondents chose patient contact and feedback, seminars and speakers in that order. No one elaborated on why.

6. Do you feel too much time was spent on any one area? Which? Six of the seven volunteers felt no subject received too much time, while one felt that the afternoon sessions drifted and "should stick closer to subject matter."

7. Do you feel that the group interaction was helpful or not? All seven volunteers felt that being part of the group was most helpful. "The group is very congenial." "We all share a common interest." "You get a review of many cases one cannot cover personally." "It helped us to feel at ease with our co-workers." "It was good to be able to help each other."

8. Do you have any suggestions for future training programs? Although not everyone had a suggestion, the few that were made included having training run for a longer period of time, having counselor-assistants go on rounds with the social workers and a desire to see pertinent films.

Graduation from training

The director of social service and I decided that following the completion of the training course, each counselor-assistant should be awarded a certificate. It was decided that this certificate be presented at a small ceremony to which representatives from administration, public relations, the mental health association and our social work

staff would be invited. The hospital would provide refreshments and an attractive reception room in the nurses residence was reserved.

The rationale behind such a celebration was several fold. We wanted to create for the trainees, a sense of completion for one phase and impetus to enter the next. They had done well and deserved notice. The certificate we had prepared[23] was both to honor the trainees and make a statement about how meaningful their training had been. By creating a ceremony and small party, good group feeling and mutual pride was fostered.

Having a representative from the M.H.A. at the ceremony acknowledged the roots of the program as from another agency and was hoped to encourage further cooperation between M.H.A. and the hospital. Having hospital administration present showed the high value placed on the counselor-assistants program, and reinforced good feelings of the counselor-assistants for the hospital and even visa versa.

All the social workers made time to be present to show their support of the new breed of volunteers and their pride and pleasure in being a part of the new program.

The public relations person was there to witness the congratulatory speeches, awarding the certificates and general high feeling among all participants. She gathered material for a story to be given to the local press. A hospital photographer took many pictures of the participants for possible inclusion in the newspaper.

It was a memorable event for all. The counselor assistants expressed pride in their accomplishment and were pleased with the recognition. "Now, wait 'til my husband sees my diploma!" "You know, I thought such a ceremony wasn't important, but I am really delighted

with all the fuss." "Now, we'll really have to mean something in the hospital." "The whole experience has been exciting, and now this really puts the frosting on the cake!"

With the note of celebration still very much in evidence, the whole department was prepared to start institutionalizing the program on the next day scheduled for the new graduates to come in. Each counselor-assistant would report to the social worker to whom he or she was assigned and actual work would begin.

Systems change seen in producing the program

In the implementation phase of this program, a variety of subtle changes could be seen to occur in the hospital. As one of the conditions of social change about which Richard Appelbaum speaks in his book,[24] we can view this within the context of homeostatic condition in systems. The pebble thrown into the quiet pond causes some rippling effect throughout the water.

This could be seen in the hospital system via implementation of the program. Social service, an adjunct and in fact, prestige-lacking department in the hospital, was suddenly visible and innovative. In this small instance, the department was a leader asking cooperation and input from other hospital departments, rather than taking directives from or mopping up after them. There almost seemed to be something symbolic (although planning had begun before the program was implemented) in the move of the department from its location in the basement to the now sunny offices in the center of the third floor!

Administration, although concerned about the hospital input

into the program, was having new and unheard of dialogues with the social service department. How our work could increase the image and better public relations for the hospital was new thinking. The department is, of course, not seen as money-making or always crucial to medical needs of patients, but with the program as a vehicle, the social service director could do more to educate administration to concomitant patient needs and to the department's ability to handle these.

Relationship with the nursing director improved as a direct result of our involving her in the training program for the counselor-assistants. The social service director had not been able to have much contact with the head of nursing and my call to describe our program and ask her to come and speak started much more of a dialogue. We all met, discussed mutual and separate problems and again with the program as a vehicle, established much greater understanding. The nursing director was most positive toward the new program and therefore the department.

Similar responses came from other departments also contacted to help in the training. Discussing the new program became a means of opening up communication with other departments on a new level. Asking representatives to speak to our trainees somehow brought the departments closer together. There was a new, subtle sense in the hospital of social service as leading a new and uniting movement in the hospital in which other departments were participating.

The communications necessary to implement the program were far-reaching and opened lines with the social service department not really used before. The housekeeping department, for example, not

generally involved with social service, was heavily involved because of the necessity of planning the physical space. The patient representative was made a part of the planning and work with her proceeded along redefining our roles together. Since social service was implementing a program which was to augment patient services and was in open communication with other departments around this area, common goals could be looked at and closer relationships developed among the various departments. Involving other disciplines both opened communications with them and gave evidence that they were respected and important in total patient care.

It had not been the goal of the program to better the image of the social service department, or to increase communications between this department and the rest of the hospital, but such unanticipated consequences were positive and important to note. They proceeded from implementation of the program and then contributed to its institutionalization.

Footnotes

[1]Charles Guzzetta, Notes from Lecture (April, 1975).

[2]Charles Guzzetta, "Curriculum Alternatives," Journal of Social Work Education (Winter, 1972), 24-30.

[3]Guzzetta, Notes from Lecture.

[4]See: Appendix F, Handbook for Counselor-Assistants, for specific definition.

[5]Malcolm S. Knowles, "Innovations in Teaching Styles and Approaches Based Upon Adult Learning," Journal of Social Work Education (Spring, 1972).

[6]Ibid.

[7]H. Aptekar, "The Curriculum-Building Process," Journal of Education for Social Work (Fall, 1968), 5-15.

[8]Mary Louise Somers, "Concepts of Learning and Teaching Theories to the Explication of the Role of Teacher in Social Work Education," Journal of Education for Social Work (Fall, 1969).

[9]William C. Richan, "A Theoretical Scheme for Determining Roles of Professional and Non-Professional," Social Work, VI: 4 (October, 1961), 24.

[10]Ibid., 25.

[11]Florence Hollis, Casework: A Psychosocial Therapy (New York: Random House, 1964).

[12]Sidney Fine and Wretha W. Wiley, An Introduction to Functional Job Analysis: A Scaling of Selected Tasks from the Social Welfare Field (Kalamazoo, Mich.: The W. E. Upjohn Institute for Employment Research, September, 1971).

[13]Ibid., 20.

[14]Robert L. Barker and Thomas L. Briggs, The Differential Use of Social Work Manpower: An Analysis and Demonstration Study (New York: National Association of Social Workers, 1968).

[15]Ibid., 14.

[16]Ibid., 165.

[17]*Ibid.*, 146.

[18]*Ibid.*, 184.

[19]Harold Lewis, "The Anatomy of Skill" (unpublished paper, January, 1975).

[20]Benjamin Bloom, *Taxonomy of Educational Objectives: Cognitive Domain* (New York: McKay).

[21]See: Appendix F, Handbook for Counselor Assistants, Tasks of the counselor-assistant.

[22]See: Appendix D, Resource Manual.

[23]See: Appendix G, Certificate of completion of training.

[24]Richard P. Appelbaum, *Theories of Social Change* (Chicago: Markham Publishing Co., 1970), p. 65.

CHAPTER VIII

INSTITUTIONALIZATION OF PROGRAM

Supervision by Social Workers

When the counselor-assistants "graduated" from training, we could say that the program had been developed, initiated, and implemented. Its institutionalization began when the counselor-assistants started to report to individual social workers at White Plains Hospital. Two counselor-assistants were assigned to each of the full-time social workers and three reported to me.

Each counselor-assistant came to the hospital by 9:30 a.m. on each of two days. After signing in at the volunteer office, they reported to the assigned social worker. At this time, the counselor-assistant would be given a patient assignment with information known by the social worker about the patients. Counselor-assistants were assigned to patients on the basis of which patients the social worker thought could benefit from this contact. Other reasons for assigning particular patients included the need of the social worker to obtain information regarding the patient, usually newly admitted, or special request by another staff member for counselor-assistant services. Once the counselor-assistant saw a particular patient, the patient was seen in follow-up visits by the counselor-assistant. Since the counselor-assistants arrived only two days each week, if planning or changes had occurred with this patient, the social worker would impart such information before the counselor assistant would revisit the patient.

At a prearranged time, the social worker was available for a meeting before the counselor-assistant left for the day. This was set up to discuss experiences with patients during the day. In this way, the social worker would receive information about her patients and would also have feedback from the counselor-assistant about his or her own feelings. During this time, information sharing and supervision would take place. The social workers were attuned to helping the counselor-assistants deal with difficult situations, and to help them over the frustrations and anxieties that were bound to occur. Some attempts were made during these times to share social work concepts along with concrete information. At all times the social workers were instructed to show appreciation of the efforts of the volunteers assigned to them.

The social workers, while supportive of the program, found that they initially needed a great deal of time to work with their assigned counselor-assistants. The social workers devoted much time to helping the counselor-assistant to overcome job-related anxiety.

By midway into the pilot project, the investment of time leveled off. The counselor-assistants were by then, familiar with their role, territory and had had enough experience with patients to need less help and support with this on a daily basis. The social workers still gave support, showed genuine appreciation and were available for problems, but were finding the help of the counselor-assistant in seeing patients outweighed any time they spend with the counselor-assistant. A greater supportive role was taken on by the group meetings as described below.

Group Meetings

Once each week, I met with the group of counselor-assistants in my capacity as program coordinator. This was planned for one and a half hours during which we brought and ate lunch and discussed general areas of concern. These meetings were set up for a variety of purposes. First was group supervision, which was really a continuation of training. This was an arena for discussion of problems and pitfalls in carrying out the role of counselor-assistant, as well as for sharing rewarding and gratifying experiences. Group members could respond to what was brought up, and I would try to summarize their remarks and develop principles on which they could act. New resource information, hospital directives, etc., could be given to the counselor-assistants during these group meetings. Another rationale for meeting as a group was continuation of group solidarity and support. The counselor-assistants were sharing a unique experience and formed a kind of "in-group" which gave comfort and pleasure and acted as a reward in itself for participating in the program.

Initially the meetings included recitations of work done and discussions of many housekeeping details, i.e., how to fill out forms, where to put specific documents, how to recommend services, etc. The need of certain counselor-assistants to dominate discussion, and others to withhold became apparent and had to be worked with. We discussed issues which had to do with resources, hospital policies or specific topics like blindness, cancer, etc. How a counselor-assistant dealt with a specific problem was shared, so all could learn from each other's experience.

One counselor-assistant who had dealt with her own mother's going to a nursing home, spoke of answering questions a patient had about life in such a facility. This helped other counselor-assistants to be prepared to respond to such questions. A counselor-assistant asked how to obtain a specific minister for a patient and another who knew someone active in that church agreed to set up the visit. The minister was with the patient by the next day. The wish of a terminal cancer patient for a hairdresser was heard by one of the counselor-assistants who described how she went about obtaining such a service for the patient while the hospital beauty shop was closed during construction. These are but a few examples of learning by shared experience which came up in the group meetings.

At one meeting, a counselor-assistant spoke of not going into the room of a male patient who was crying because she was afraid she would embarrass him as "men don't like women to see them crying." The group was able to discuss alternative ways of handling such a situation and the counselor-assistant gained some insight into her own needs in this situation.

The group meetings were useful in discussing policy questions. Initially these revolved around hours, questions of whether volunteers could eat in the cafeteria, decisions as to how much to do for patients, etc. By the second month, the question of follow-up was addressed. Although the program was designed to include follow-up phone calls to discharged patients, one of the social workers raised questions about this with her counselor-assistants, and it was taken up at the group meeting, and with total staff. It was agreed that the follow-up calls might raise problems which would not be possible to deal with

because of the heavy caseloads of the social workers. Thus, it was decided that routine follow-up would be discontinued. When the counselor-assistant wished to contact a discharged patient, he or she would check with the social worker before doing so.

Relationships between counselor-assistants and nursing staff were discussed and how to be helpful and obtain cooperation of nurses was a lasting topic. By the second month, the counselor-assistants expressed interest in being readily visually identified with the social service department. Social service patches were obtained which the counselor-assistants were glad to sew on above their name tags on the smock or jacket they wore.

From a forum for "experience-swapping," the weekly group meetings grew to general discussion, policy decisions, and work on completing forms. By the third month, the counselor-assistants were ready to bring up specific topics on which they wanted to have more information. Death and dying, cancer, confused and agitated patients, evasive and suspicious patients, were a few of the areas suggested. A short lecture given by program coordinator and a discussion following began in this last month of the pilot phase. Such talks, combined with planned speakers and tours of various facilities continue at the time of this writing for those counselor-assistants who have remained at the hospital.

Patient Contacts

Each counselor-assistant saw a variety of patients during the three-month period of the pilot project. The number of patients seen

by individual counselor-assistants each day varied from two to eight and was determined by a wide variety of circumstances. Most important was the ability of the counselor-assistant and the expectation of the individual social worker. The nature of the patient's illness, whether they were available to be seen, how much they needed to talk, etc., strongly influenced the work load of each counselor-assistant.

After speaking with the social workers, each counselor-assistant would take notes from the hospital admission slip or social service record, if there was one on the patient he or she was to see. This was done to orient the counselor-assistant to the patient, as well as to note specific demographic data which they would eventually turn in to the program coordinator for research purposes.

Following this period of writing, the counselor-assistant would go to the floors to see the assigned patients. Each counselor-assistant was expected to introduce him or herself and explain their role, and then to visit with the patient. In cases where the patient was known to the social worker and was seen to need companionship, support or special services, the counselor-assistant would try to provide these. In other cases, the counselor-assistant would be asked to see a new patient, chosen because they were over 60 years of age. In these situations, the counselor-assistant would attempt to obtain specific information from the patients in order to report this back to the social worker. It was the social worker who would determine a plan for patient both from data given by the counselor-assistant, and by her own patient interviews. Where specific planning and social work intervention was necessary, the social worker would see the patient, and the counselor-assistant would continue to visit twice a week. When the

patient was seen to benefit from counselor-assistant visits and no other specific planning was necessary, the counselor-assistant would be the main link between patient and social worker.

The counselor-assistants saw both male and female patients of all ethnic groups, religions and socioeconomic classes. The patients initially responded to the counselor-assistants with feelings running the gamut from suspicion to open pleasure and gratitude. The patients they were to see could be anywhere from up in bed, delighted to talk, to deeply asleep. At times, the patients were out of the room at x-ray, physical therapy or the like. As expected, at the outset, the possibilities for variability were seemingly endless. The kind of interaction the patient and counselor-assistant had was related to the personality and style of both, as well as the medical and emotional condition of the patient, and even the expectation of the supervising social worker.

Counselor-assistant visits might begin by explanation of the new program or discussion of the patient's health. Patients generally seemed interested in talking and, unless very ill, eager to relieve the boredom in the hospital in this way. Depending upon the lead of the patient the counselor-assistant would listen to the patients' concerns, fears and hopes, or would participate in a general discussion about world or local events, etc.

The counselor-assistants were instructed to learn what they could about each patient. Key phrases of "who is the patient," "who was the patient" and "who does he plan to be" were suggested to orient the thinking of the counselor-assistant. Specifically, "who the patient is" concerned what kind of person he seemed to be; what he does

when he is not in the hospital; where and with whom he lives; kinds of relationships he has; things he likes or dislikes. "Who the patient has been was included in past history of work, relationships, living situation and reminiscences. "Who the patient plans to be" encompassed the patient's thoughts on his future, his feelings about his medical conditions, how it will affect his life and what his hopes and expectations are, as well as his concerns and fears. Certainly, not all of this information could be obtained in even a few interviews. However, the concept was used in helping the counselor-assistants begin to categorize information which the patient shared during their visits.

If the social worker needed specific information for hospital casework operations, during the course of the visit to the patient, the counselor-assistant would ask appropriate questions to get this information. If there was concern about imminent discharge, the counselor-assistant would try to ascertain what plans the patient and family had in this regard and report these back to the social worker. Otherwise, the counselor-assistant would discuss areas brought up by the patient. There was many a conversation in which the patient spoke with the counselor-assistant about how things were in days which they both remembered. One of the counselor-assistants reported a conversation in which a woman was telling him how she had decorated her apartment and was delighted when he knew exactly what she was describing as the once-used glass covers on electric poles! Another counselor-assistant was interested in a conversation she had had with a patient about the changes having occurred in White Plains where they had both lived all their lives. This ability to share and understand past events is obviously somewhat unique to two people of a similar generation.

In counselor-assistant contacts with patients, questions frequently came up regarding bills, benefits and money concerns. Some of these the counselor-assistants were able to answer directly. Others, after consultation with the social worker, they could bring back appropriate information. At times, the social worker would ask the counselor-assistant to make specific phone calls to obtain information or to help the patient apply for some financial help.

In cases where the patient was to be transferred to another facility, the counselor-assistant was available to bring information to the patient about the facility. Any place with which the counselor-assistant had personal contact, he or she could easily share knowledge and impressions. About facilities with which there had not been this kind of familiarity, the counselor-assistant was able to ask the social worker, read resource books or pamphlets available and discuss what he could about the new institution.

In many instances, requests by patients for small concrete needs were picked up and arranged for by the counselor-assistant. Either by apprising the social worker or nurse, arranging for the patient to purchase, or bringing in items themselves, the counselor-assistants were able to help patients to get pencils, stamps, books, hobby materials, needle and thread, etc. The counselor-assistant was instrumental in informing the social worker of the patient's wish for extra clothes while hospitalized. Then the social worker could arrange for the family to bring the necessary items. Mention was made earlier of counselor-assistants helping patients to obtain services of a minister, and of a beautician. In a number of cases, counselor-assistants were very helpful in assisting patients in obtaining

homemaker help. Under the direction of the social worker, one counselor-assistant gave help in referring a patient to A.A. Several times the counselor-assistants were able to make helpful suggestions to patients for resources like the Senior Center, special transportation, volunteer opportunities or nutrition programs.

Patients seemed generally to be pleased with the extra attention they received. They often felt that it was the counselor-assistant who could help them with the small, but comforting details that they might never even think to "bother" their doctor, nurse or even social worker with. In specific instances, a remark from the patient illustrates how meaningful the contact was for him or her. One man stated, "I've been to this hospital before, but it has never seemed so warm and human before." A woman, having spoken of numerous concerns and angers to one of the counselor-assistants concluded by saying, "Now, I've talked it out, and I feel so much better." Many patients spoke of how they didn't need anything specific, but so much enjoyed having a special and understanding person to talk to. Some patients were openly grateful for the contact and let the counselor-assistant know they looked forward to each visit. Others were not as enthusiastic, and a few were angry, generally, and not changed by contact with the counselor-assistant. It was important that the issue of the anger that an ill person might displace toward the people around them was understood by the counselor-assistants. This had been discussed in the training program in order to minimize any reaction that the counselor-assistant might have to the hostile patient.

Counselor-Assistant Contacts with Hospital Personnel

During the three months of actual work put in by the counselor-assistants, hospital personnel had varying reactions. Those representatives from other departments who had given lectures during the training program were aware of the counselor-assistants and most welcoming and receptive to them. Others who did not have direct contact were not really aware of who our newly-trained volunteers were. Most of the physicians were unaware of their presence, although in discussion, they always felt the idea was good and that it was suitable for their older patients.

Major contact for the counselor-assistants other than social workers and patients was with the nurses on the units in which they were seeing patients. The reception given to the counselor-assistants was variable and dependent upon personality and style of both nurse and counselor-assistant, as well as the expectation of the counselor-assistant, social worker and workload of each person involved. Even the extent of contact was variable. In some cases the counselor-assistant would just see patients and barely talk to the nurses. In other, they might question the nurse for information, bring communications to the nurse, and spend considerable time interacting. While the overall reception of the counselor-assistants by the nursing staff was very positive, there were times that some of the counselor-assistants felt they were not respected by the nurses. Other times the counselor-assistants felt that the nurses really didn't know the patients and therefore the counselor-assistants felt disappointed in the nurses.

In some units, the response of the nurses was not only positive it was downright grateful. On the cardiac care unit, after approval from the social worker, the head nurse began referring patients directly to the counselor-assistant when she felt any older patient needed some one to "talk to." Another unit also began to change the nature of referrals to social service, from purely "disposition problems" to include "older patients who could use companionship." In the case of one very regressed patient, the counselor-assistant obtained permission to feed the patient one meal, to stimulate some interaction. The nurses were relieved of this time and patience-consuming task and were grateful to the counselor-assistant for her help and sensitivity to this patient.

One of the units in the hospital is called "primary care" and is devoted to the idea of having one nurse totally responsible for a few patients, rather than splitting tasks. This is in comparison to the usual unit where different nurses take charge of different tasks, i.e., one gives out medications, one bathes patients, one is in charge of rooms and beds, etc. On the primary care unit, the staff knows their patients particularly well, and has always been more attuned to appropriate and early social work referral. On this unit the counselor-assistants were easily accepted as part of the team, and the nurses would seek them out to inform them about a patient they were seeing.

It is interesting to note, that on one of the units where nurses were positive toward the program, but did not interact generally with the counselor-assistants, there was some deference to the male counselor-assistant because he was male, and because he felt secure with hospital routines, charts and personnel. Although generally the

counselor-assistants were instructed to see patients and perhaps speak to nurses, they were not to read hospital charts. When the male counselor-assistant asked the nurses something, they would direct him to the chart much as they would the physician.

The nurses seemed to view the counselor-assistants as an arm of the social service department, and as an aide in making patients more comfortable, although except for special incidents, not a specific help to them.

Particular Satisfactions for the Counselor-Assistants

The newly trained volunteers derived particular satisfaction from their special status, group feeling, interactions with staff and work with patients.

Special status. The counselor-assistants were very aware of their special place in the hospital. Volunteers are highly visible and highly valued at White Plains Hospital. There is often expressed an assumption that help given by a paid employee is "nice but expected," while that given by a volunteer is especially appreciated because the volunteer "really wanted to perform the service." The counselor-assistants were volunteers as shown by their pink smocks (female uniform), and red jackets (male uniform), but were a group set apart. They were arms of the social service department. They had all graduated from the special counselor-assistant training program and were not interchangeable with other hospital volunteers. The commitment they made was great, but it entitled them to a very meaningful role, to confidential communications and to license to use themselves creatively.

They enjoy a special comradery in the department and open invitation to attend staff functions.

<u>Group feeling</u>. The counselor-assistant drew much pleasure from the group cohesion which developed. The counselor-assistants enjoyed their work, both in the doing and in the sharing of the experience. The group provided a forum for such exchanges as well as a base from which to draw nurture. Each person was supportive to the others in the face of difficult experiences with patients. They were also available to listen to each other's personal troubles and respond with notes and concern if a member was ill.

One of the counselor-assistants began to have trouble with her unemployment checks stopping. She became depressed, but did receive support from her colleagues and continued to work in the program until the end of the pilot project period. Group members were concerned and this allowed the counselor-assistant to express her fears, and derive satisfaction from being heard. This same counselor-assistant was touched and bolstered by our having a little party for her when she left the program to make an extended visit to her daughter in California.

<u>Interactions with staff</u>. The counselor-assistants found it gratifying to be included as part of the social service department. Relationships with other hospital personnel were based on this, and great satisfaction occurred when a patient was referred directly to a counselor-assistant, or a nurse would respond colleaguely or with great gratitude for the work the counselor-assistant was doing.

The counselor-assistants enjoyed the respect and appreciation

of the social service director as well as the individual social workers and program coordinator. This was most important in the sense of satisfaction they derived. They were all most pleased with praise and appreciation. Some needed this more than others, but such verbal, as well as non-verbal communications from social work staff was most important in satisfaction they derived.

Satisfaction at being part of a team would occur when social workers would share information and engage in a dialogue regarding the patient. The feeling of being needed and appreciated was obtained whenever the counselor-assistant saw tangible evidence of having helped a patient, given service for the social worker or become the recipient of statements from the social worker regarding how she could not manage as well without him or her and how grateful she was.

Work with patients. The major satisfaction derived by the counselor-assistants was in their contacts with patients. The counselor-assistants were always so pleased when a patient overtly expressed gratitude. Comments from patients like, "It was so good of you to talk to me," "Please do come back again. It meant so much to have you here," reinforced the good feelings the counselor-assistants had about what they were doing. A patient who would cling to the hand of the counselor-assistant or would actually hug the counselor-assistant gave satisfying evidence of feeling close and grateful. Not only were these actions by patients satisfying in themselves, but the counselor-assistant enjoyed reporting such instances to each other when they met.

Besides overt expressions of joy and gratitude given by patients, the counselor-assistants developed satisfaction in working on and then

helping to develop a relationship with a patient who had been suspicious or difficult. One of the counselor-assistants reported visiting a woman who was curled up in her bed under several layers of covers and who barely looked up when the counselor-assistant came into the room. After some time, the woman not only talked to and looked at the counselor-assistant, but even brought her hands out of the blankets and began to sit up more. The counselor-assistant reported this episode with pleasure, both because the patient received some comfort and because she was aware of having made a difference to the patient.

When the counselor-assistants were able to help either by doing some concrete service, or by listening, empathizing and supporting, they were most pleased. Although in the course of their seeing patients, they might be asked to bring up a form, make specific phone calls, or the like, they generally derived most satisfaction from the positive contacts they had with patients.

In some instances the visit or conversation with the patient was such that it in itself produced gratification. Depending upon the particular counselor-assistant and the patient such talks were a major highlight. One counselor-assistant, in particular, was very maternal and had no prior expectation of any patient. She almost routinely came back to her social worker describing the "delightful conversation" she had had with the "lovely" woman or "charming" man she had seen. She was able to report areas of problem for patients she saw, but generally viewed her role as just getting to know people and exchanging ideas. It was stimulating and enjoyable for her, and patients that she saw were buoyed up by the visit and eager to have more.

The counselor-assistants liked the idea that they were helping patients feel better and more connected to the hospital and the social service department, and were happy about helping give information or suggestions regarding community resources. In most ways they derived great satisfaction from performing these linkage functions for the older hospital patients. Tasks for such function were seen as inherently interesting and meaningful, as well as needing special skills. One of the counselor-assistants reported that she felt "ten years younger" since starting the program. Another mentioned that she was "excited about getting up in the morning" on the days she came to the hospital. Still another stated that she was "so pleased to be doing something so worthwhile." Counselor-assistants made special arrangements where necessary so as not to miss coming and were absent only when unavoidable difficulties occurred.

Particular Frustrations for the Counselor-Assistants

There were frustrations both inherent in the program and because of the personality or life circumstances of the particular volunteer.

Difficulties because of hospital policy

Parking. A major area of difficulty for employee and volunteer alike, in working at White Plains Hospital is lack of proper parking facilities. There is an inadequate employee lot and a secure but very small parking lot in which volunteers can park their cars without charge. Unfortunately, to make use of this lot, one has to arrive there

close to 8:30 a.m. in order to find a space. Once it is full, the volunteer is on his or her own to either park at one-hour meters close to the hospital and run out to feed it, or go further to find parking lots with longer lasting meters. The extra time, effort, and walking required are unpleasant and very frustrating. The counselor-assistants accommodated to this annoyance. One started coming very early to use the volunteer lot. Two others accepted the difficulty and found parking. Three others were driven up and back to the hospital by other family members and one walked a half mile to come.

Eating. Once the training program was over and with it free lunches in the cafeteria, the problem of where to have lunch arose. A couple of the counselor-assistants had been informed that they were supposed to eat in the coffee shop and not in the lower-priced cafeteria. There was some anger and frustration over this and the decision made to bring food and meet over lunch. The policy was ultimately clarified by the hospital administration and the volunteers are free to use the cafeteria as well, negating some of the original frustration.

Problems relating to nursing staff

Most relationships between nurses and counselor-assistants were most compatible. However, there were a few incidents where the counselor-assistant had feelings of being given the "brush-off" or being seen as in the way, by a nurse. These situations caused frustration and anger in the counselor-assistants involved, as well as bringing up concerns about their being welcome in the hospital. In some of the incidents in question, as simple an episode as of a nurse being

unresponsive to the repeated greeting of one of the counselor-assistants evoked strong feelings. A more complex example was one of the annoyance of another nurse when a counselor-assistant informed her of a patient's distress with a hospital commode. Such frustrations are impossible to avoid in a hospital setting where the mixture of disciplines, personalities and extreme pressure for all produces many strains. To offset this type of problem, discussion with individual counselor-assistants and with the total group were used. This allowed ventilation, and attempts to derive alternative ways of dealing with similar situations. Reinforcing the counselor-assistant's self-image and clarifying his or her role was supportive as well.

Prior to the training program, plans for the program were discussed with the head nurses. Ideas had been solicited and during the training phase, some of the units were visited. Each social worker had also introduced the counselor-assistants with whom she was working to the personnel on each of her units. All of these were seen as ways to minimize conflict and friction with the nursing division, and for the most part seemed to act in that way.

Difficulties in locating patients

Frustrations inherent in the program include those around getting to see particular patients. Many times the counselor-assistant would enthusiastically start on his or her rounds to see several patients, only to be thwarted at every turn. One patient would be receiving his bath. The next was out of the room at x-ray and the third could be soundly sleeping. By the time the counselor-assistant

tracked the fourth patient down to physical therapy, only to find that this patient had already begun working on his exercises, the counselor-assistant himself, felt he had had an "exercise in futility." Initial difficulties in getting to see patients might even be compounded by further frustration as the counselor-assistant returned to try each again. An exaggerated situation such as this was infrequent, but these kinds of blocks to seeing patients did happen and did cause frustration for the counselor-assistants.

During training, the counselor-assistants had been prepared for such occurrences. At times when they actually occurred, sharing such frustrations with a sense of humor was most effective. Trying to rearrange their scheduled visits to specific patients was often helpful as well.

Difficulties relating to problem patients

The counselor-assistants experience a variety of problems relating to certain patients. Some patients were a bit suspicious of this "special volunteer" who came to talk, or to obtain certain information and would respond to initial overtures with overt hostility. The counselor-assistants had to be helped to overcome understandable fears about this kind of patient. They had to be very clear about their own role in order to deal with this situation. The counselor-assistants needed help in feeling that they, indeed, did have a valuable service to offer, even when they were not needed for anything concrete. They also were helped with techniques of listening for information, rather than walking in to a new patient with pencil and face sheet in hand.

The counselor-assistants also came to understand that much of the anger and frustration the patients feel as a result of being ill can be displaced on the people who come to help them.

Some patients in the hospital were periodically confused and dealing with the confusion was difficult for the counselor-assistant. Such patients might not only forget who the counselor-assistant was, but might be unaware that they were in the hospital at all. One such woman spoke of needing to return home to care for her young children. The counselor-assistant was aware that this 79-year-old woman lived alone, and in fact, had adult children and even grown grandchildren. The counselor-assistant was concerned about how to respond to such talk from the patient. During supervision, explanations of some of the dynamics behind the patient's productions were given, and the counselor-assistant was helped to see the patient and respond to the affect shown by the patient; the anxiety, pressure and fear. She was also able to give orienting data when she came in as to her own name, the date, the kind of day, etc. This later technique had been suggested as one of the standard supportive approaches to a confused patient.

Severely regressed patients proved frustrating to the counselor-assistants as well. In several instances, the social workers suggested that the counselor-assistants not continue to see such patients. In some, the counselor-assistant was instructed to stop in and see how the patient was doing to attempt to keep up some contact. One particular example was of a 62-year-old woman admitted in April of 1976 in cardiac arrest. This patient in two months rallied physically, to the point that transfer from the acute hospital was necessary. The

counselor-assistant was assigned to see this patient at this time. The patient was still too ill to care for herself and too regressed mentally to go home. Nursing home placement was suggested. While the social worker was very involved with a difficult family to effect this placement, the counselor-assistant continued to see the patient who was generally found curled up in bed in a fetal position. As the family showed less and less interest, the patient's depression and regression increased, and the counselor-assistant was supported in her efforts to continue to make contact with this patient. Although frustrating to the counselor-assistant, it also provided great rewards when on one day the patient responded to conversation and on another the patient actually waved to the counselor-assistant from a distance. This patient was actually in the hospital for six months before being transferred to a nursing home and the counselor-assistant had been able to provide consistent relationship, concern, even literally feeding the patient during this period.

It was expected that very demanding patients would prove frustrating to the counselor-assistant. As it happened, however, this was a minimal problem. On the days when the counselor-assistant did come, he or she was able to handle many requests of time to talk, concrete information, etc. Because of the reality that they were not in every day and never had complete responsibility for any patient, excessive demands for service were sometimes a minor annoyance, but were not really problematic for them. The counselor-assistant was helpful in seeing such patients, when he or she was present, and helped to see the nature of the numerous demands made. The unit social worker would, of necessity, have to contend more with such situations.

One of the most difficult kinds of patients the counselor-assistant dealt with were ones who were severely depressed. Sadness and depression, while easily understandable in hospital patients, produced much anxiety and feelings of inadequacy in the counselor-assistants. One counselor-assistant spoke of not entering the room of a male patient who was crying so as "not to embarrass him." Another counselor-assistant told of feeling frustrated because she could do nothing to help a terminally ill woman who was "viewing her life as such a waste." The counselor-assistants were helped to overcome the natural inclination to smooth things over and say everything would be fine. Of help was allowing them to air their frustration in these cases and pointing out that their companionship and understanding was useful to such patients. The counselor-assistants, being older, mature people with a good deal of life experience had already gone through many moments of their own depressions and sadness. They could identify with many of the concerns of the elderly patients whom they were seeing. It was this ability to empathize that often led to their effectiveness, but at times added to their own personal difficulties in performing their tasks. It was the supervision and group meetings where these issues were acknowledged and discussed that made it easier for them.

Some difficulties in relating to social workers

While the counselor-assistants spoke of how pleased they were working with the social workers, there were indications, especially early in the program that some counselor-assistants were insecure with regard to their usefulness. One of the social workers, particularly,

was very pressured and harried and the two counselor-assistants working with her immediately picked this up. They felt that sometimes they were "in the way" when the social worker came running in late and breathless for their conference. "I think I am really more trouble than I'm worth," said one, while the other spoke of "going out of my way not to ask questions or disturb" the social worker. In this case, the combination of two of the more insecure counselor-assistants with the then most pressured social worker led to these misunderstandings.

As the counselor-assistants became more identified with their role and the department, they became more sure of their worth and more understanding of the social worker's pressures without relating it to themselves. The social worker in question, was also helped to realize the effect her pressure was having on the counselor-assistants. She was able to meet with them at times more convenient for her, and to better fulfill their need for praise and appreciation.

The counselor-assistants found it more difficult to work with one of the social workers who filled in for vacation time. She was not as clear about the nature of the program as the regular staff and saw the counselor-assistant as something akin to a social work student. The counselor-assistants felt unappreciated and rather put off by her cooler, analytic manner. This social worker had to be helped to see that the counselor-assistants were volunteers who were giving their time and needed satisfaction. Although the counselor-assistants want growth, they were unprepared for long-term, professional type of supervision. The initial differing expectations caused some frustration, but was rectified and short-lived.

Description of How Each Volunteer Functioned in the Program

Each of the counselor-assistants has special strengths and weaknesses. It is interesting to look briefly at how these affected functioning in the program. (Initials refer back to beginning descriptions of each in Chapter V.)

V.B. proved to be an understanding and compassionate counselor-assistant. Because of her vast experience with illness and tragedy in her own family and ability to use this in empathizing with patients, she easily put people at ease. She was particularly effective in helping patients deal with transfer from the hospital to other facilities. She contributed to group discussion from her experience, but was the one counselor-assistant who felt that too much group time was taken up with this activity.

V. was committed and intense, but highly pressured. She had never really allowed herself time for mourning her mother and aunt, and when her daughter moved out of the house, the losses became too much. About three weeks before the end of the pilot period, V. was ill and told by her doctor to drop all her activities in order to have complete rest. She was physically ill and depressed, and although in contact with us still, unable to resume former activities.

L.G. was dynamic, aggressive and dramatic in her work with patients. She was able to be understanding at the same time that she used humor and drama in her relationships. She appeared self-assured and was able to give support in difficult situations. She readily applied things she learned.

L. has been a widow and lived alone for many years, and this came across in her great need for appreciation and love from the social workers as well as the group. L. had more difficulty relating to male patients and was particularly upset and offended when going to see a male patient who was rather confused and in a state of undress.

While enjoying the program and her participation in it, she was the most vocal regarding inconveniences caused by hospital policy. She was particularly beset with financial concerns because she was living on unemployment checks. Thus, she was acutely aware of things the hospital did not provide for volunteers, i.e., free lunches, discounted medications, hospital benefits, etc. L. suffered severe distress when her unemployment benefits were cut, and looking for jobs became a most humiliating and difficult experience. She needed and received a great deal of support from everyone during this time and was thus able to continue to help patients competently. Because of her own depressed state, her enthusiasm waned and at the end of the three-month commitment, she left the program to visit her daughter in California for a month. Since her return to New York, she has been in touch with the group, but had found a full-time job and can no longer participate in the program.

R.K. has been a complete asset to the program. She has been warm, compassionate and helpful to patients and has actually been very helpful to the social worker as well. She has used what she had learned to add to her natural ability to empathize. She readily goes out of her way to fulfill needs, stays late to be sure to see all of her patients and has the ability to report on her activities in a

concise, meaningful way.

R. has many outside commitments, like babysitting for grandchildren, or caring for an ailing stepmother. While she tries to work around them, there have been times she had to miss coming. Particularly since the pilot project period ended, there have been complications, but R. continues as a very active, involved counselor-assistant.

M.M. has continued in the program, as she came to it. She is quiet, compassionate and giving. Because she has not preconceived notions and is so motherly, however, she has had a most positive effect on patients. The social worker with whom she works is aware of her strengths and sends her to see patients who are pleasant and particularly in need of companionship. M. is well-suited to give this kind of service.

M. is the least sophisticated counselor-assistant and in this way balances some of the others who are more so and have grown more aware of underlying issues in a patient's behavior or illness. A major problem for M. is her dependence on her family for transportation from Connecticut to the hospital. If her son-in-law was not coming to White Plains to work, M. would have to come at 6 a.m. with her daughter, the nurse, or not come at all. This proved a most difficult problem and caused M. to miss some days during the pilot project period.

M. loves the program and truly enjoys her conversations with patients. She is still involved in the program, but can come only once a week now because of the transportation.

F.N. has been able to use the wealth of experience she brought as a psychiatric nurse in being able to deal with some very difficult patients. She is calm, patient, and always understanding. F. is eager to please and quite extensive in her record-keeping and reporting. Yet she is most flexible in the way in which she relates to patients. Whether it be to talk, to help feed or to bring in handiwork, F. has been able to relate to a wide variety of people on a variety of levels.

F. has been a major asset to the social workers she has worked with. She is most dependable, having never missed a day and always appearing early. She accepts direction and eagerly learns from each case, while being very self-directed and responsible.

F. is in touch with her own feelings and those of others. She was able to discuss initial discomfort using the phone to get information, etc., but wanted to overcome this and by practice has done so. F. enjoys participating in the program and speaks of the lift it has given her. She is aware that seeing older patients has also produced extra anxiety for her, but what she gains as a counselor-assistant, she feels is well-worth any such discomfort. F. continues in the program, pleased with her service to patients and with a sense of learning and growing.

L.W. has been able to function well in the program. She has proven well able to see patients, report back and complete necessary tasks. She is an attractive person, both in her well-dressed good looks and her warm and caring demeanor.

L. has been able to learn from the program about both community resources and emotional make-up of people, and puts such information to

work when seeing patients. Her concern comes across and she has been well-received by patients. L. has continued with the program after the pilot period despite some weeks of absence for recuperation from surgery on her vocal cords. She is now concerned about an ill family member, but feels it is better for her to continue in the program which gets "her mind off her own troubles" and offers her great satisfaction.

A.Y. has been a committed and dependable counselor-assistant. He has been particularly helpful where concrete tasks were necessary to perform. He is organized, bright and willing.

A. has been less able to comfortably talk at length with patients. When the patient is really eager for companionship, he can converse and sustain a relationship. Yet, where there is any difficulty, A. has been less able to get through to the patient. A. is a compassionate individual, but is more businesslike in demeanor and more difficult for the patients to get to know. A. tends to isolate affect which prevents him from becoming too involved or becoming too fearful with his own vulnerability.

A. has been ambivalent about supervision. He has wanted help, but becomes defensive when receiving suggestions. Because of his prior role as independent hospital pharmacist which caused him to feel secure in the hospital setting, he has great difficulty with the insecurity caused by his new role as counselor-assistant. That he is senior and male, operates in his ambivalence toward supervision by a young female social worker.

Despite these difficulties for A., he, too, has continued with

the program after the end of the pilot phase. He enjoys coming and sees it as a commitment just like a job. A. also enjoys the group meetings and contributes useful data to these. Being the only male has not been an impediment to him. It has, in fact, been even another source of satisfaction. On the whole, A.'s participation has been most satisfying for him.

Difficulties Encountered by Social Workers in Supervising the Counselor-Assistants

Each social worker had her own style of supervising, just as each counselor-assistant had his or her own style of relating. Yet, certain problems of interaction emerged because of the nature of the program.

Nature of the role of counselor-assistant

Since this was a project to try a new approach of providing a linkage service, there were no hard and fast guidelines for behavior for any of the participants. While there had been much discussion prior to instituting the program, when the counselor-assistants finished their training and were ready to work, there was some initial floundering as to how to really use them.

The social workers debated whether to screen cases first and then assign counselor-assistants to see people, or to allow the counselor-assistant to do initial interviews. This had not been spelled out clearly in the program design as it was purposely left flexible. Within a short time, the social workers could themselves,

assess the capability of the counselor-assistant and what kinds of assignments he or she could most comfortably handle. In one instance, the counselor-assistant was sent to see a lonely, but very angry man. The counselor-assistant returned rather shaken and upset. This social worker supported what the counselor-assistant had tried, but suggested the patient not be seen again. In a similar situation involving a different counselor-assistant and different social worker, the counselor-assistant was given support and helped to continue to stop in on the angry patient who in this case finally spoke with the counselor-assistant, indicating remorse for having been "so upset and rude" at earlier encounters. The varieties of approaches and responses were, of course, dependent on differences between patients, social workers and counselor-assistants. In all situations, the social worker in supervising the counselor-assistant would assess the ability of the counselor-assistant to handle specific problems and would try to deal with the situation accordingly.

Because the program was new, the social workers also had to work out themselves what tasks to assign to the counselor-assistants other than speaking with patients. Some counselor-assistants phoned agencies in order to obtain information. Others were ready to put forms on charts or speak to family members. Some of the counselor-assistants and social workers were less comfortable with such tasks and because of the developing role of the counselor-assistant, unsure how much to push in either direction.

Age and experience of the counselor-assistants

There were some difficulties in supervision because of the age and experience of the counselor-assistants. The fact that this was a special group of people "over 60" made them different from other volunteers who are generally younger and less committed. The counselor-assistants had been each successful and productive people in their own right, and yet were part of the program because of their professed desire to help and to learn. There was some initial intimidation experienced by the social work staff in doing supervision with them. Each erred in allowing the counselor-assistants to do too much on their own, and were then surprised at the insecurity shown by the counselor-assistants.

The social workers came to realize that while the counselor-assistants were more experienced in life and in their own fields, they needed and expected guidance from the social workers in performing the tasks in their new role.

Showing appreciation while helping the counselor-assistants learn

A very real dilemma, still not solved completely is that of answering the need of all the counselor-assistants for support and appreciation, while helping them learn and grow in the role. Learning occurs in the individual time with the particular social worker when she discusses how a patient has reacted to what the counselor-assistant did. In such instances, it is felt, the social worker has to carefully go over the situation so as not to intimidate the counselor-assistant,

while pointing out what did occur in the interaction. The social worker also helps give isolated facts, with regard to the patient, illness or community resource in each case that she goes over with the counselor-assistant.

Despite some initial intimidation of the social workers, they quickly passed beyond this, and realized how needy each counselor-assistant is of support and praise. The counselor-assistants, as a group, spoke of their participation in the program as enhancing their self-esteem. Social workers became aware of the feelings of the counselor-assistants about their own age and non-participation in the labor force, and how important it was to enhance the positive aspects of their time at the hospital. Both because of the nature of the group and because these were people putting in a considerable time commitment as volunteers doing a worthwhile service, supervising was at times difficult.

In the group meetings, learning was facilitated by group discussion and support. Specific areas of difficulty could be discussed as common problems and be less threatening to the counselor-assistant than if brought up in individual supervision. An example of this was when one of the social workers felt that the counselor-assistant with whom she was working was taking too much time writing information and not enough seeing patients. The counselor-assistant was reported to be not able to see any problem in this. In the group, I brought up the discussion of how the counselor-assistants spent their time and kept their forms and notes. Following this, when the counselor-assistant became aware that only he was using a particular method, he was able to discuss changes with his social worker, and become more productive.

The group meetings were used as sessions for support, complaint and learning about specific topics and were an important adjunct to the individual supervision which the counselor-assistant received.

Ending of the Three-Month Pilot Phase

The program was functioning with seven volunteers actively involved. By mid-October, 1976, the three-month pilot phase had ended. The counselor-assistants were instructed to complete data sheets on patients only until the end of that phase for the purposes of assisting in the evaluation of the program. They also completed forms at that time to give their feelings about the program. The two counselor-assistants who had to leave the program had stopped coming by the end of the pilot phase.

Other than those changes just mentioned, the five counselor-assistants who remained have continued coming to the hospital to see patients and do related tasks. Group meetings have continued. During these, guest speakers from special services like Alcoholics Anonymous or the Lighthouse for the Blind are invited, or the whole group goes to tour a particular facility in the community such as nursing homes, terminal cancer facility, or a rehabilitation hospital. The counselor-assistants are seen as a part of hospital service. Institutionalization of this program to involve senior citizen volunteers in providing a linkage function for senior patients had occurred.

CHAPTER IX

EVALUATION OF PROGRAM

Attempts to evaluate this program must, of necessity, be rather descriptive in nature. We are dealing with the assessment of a newly-formulated program, with the myriad of variables that it entails. As such, it is one that is rather nebulous and flexible. The problems that are inherent in doing any evaluation research are here not only compounded, but lead to the need to look at this program for broader genralizations, which could be used in the future for evaluating such a program with a more tightly controlled research design.

Evaluation Defined

Evaluation is research done specifically for the purpose of assessing efficacy of social programs. Since "research" is the systematic, objective, controlled investigation for public knowledge,"[1] including it in any report of a program mandates that we attempt to proceed in an orderly way to study data, using empirical evidence. Evaluation uses research to relate "program" to "outcomes." It will "assess the effects of an organization's existing projects or programs on their direct participants, other designated groups and/or specific institutions."[2]

Evaluation tries to measure the effects of programs against goals it sets out to accomplish. Therein "lies the rub" for this program. It is difficult in the best of circumstances to identify and

then evaluate "outcomes." We are dealing with complex, difficult to observe activities which are made up of "many elements acting in diverse ways."[3] We are also dealing with goals of programs which are often nebulous and intangible. Combining these elements provides a frustrating, if not harrowing, experience.

In this dissertation, "evaluation" will include defining program, goals and outcomes as closely as possible. Yet, it is premature to develop anything resembling measures of effectiveness when what is important here is to look, as objectively as possible, at general overall accomplishments or deficits and at the innumerable variables involved.

Definitions of Terms

In this section, we will attempt to provide a summary which can be a framework for the discussion that follows. While we are not going to evaluate effectiveness of the program, we can break down definitions into independent and dependent variables. Independent variables are those that are involved in input into the program. The nature of the service, who it is provided to and by whom are questions addressed by the independent variables.

Definition of independent variables

The Pilot Project refers to the package of activities that went into providing a new service in the hospital. Included in this were the processes of preparing the environment to receive a new program

and recruiting and selecting people to participate in it, as well as instituting the program.

The Program includes conducting training sessions to enable participants to give specific service and then using these people to, in fact, give that service.

Counselor-assistant is a person who was selected, trained and had agreed to provide special service for hospital patients. Such a person was to work four hours on each of two days a week and report directly to a specific social worker as well as participate in weekly group supervisory sessions.

Service given by counselor-assistants was mainly that of visiting, speaking with and listening to specific patients assigned by the social worker. The counselor-assistant was to act as liaison between patient and social worker, or patient and nurse where this was appropriate. He or she had access to information regarding community resources and upon direction of the social worker would share this with patients and where necessary enable patient to use these. Concrete services for patients in the hospital could include making phone calls, writing letters, obtaining needed items, helping with forms, securing outside services such as hairdresser, minister, etc., or accompanying patient to other areas of the hospital. Service of a counselor-assistant could also include things to help the social worker with specific patients, i.e., putting a form on a chart, relaying a message to nurses, family or outside agency, or even making calls to obtain general information when necessary.

Social worker refers to any of the professional social work staff at the hospital. Included are the Director of the Department, two full-time Master's of Social Work and one part-time MSW. The fourth worker is a part-time vacation relief person who has no MSW, but has ten years of experience working at the hospital.

The hospital is a 300-bed community acute care facility called White Plains Hospital. It is situated in White Plains in Westchester and draws patients generally from surrounding communities. Patients coming from New York City or out-of-state are at White Plains Hospital because they became ill while visiting a family member in the hospital area.

Patient refers to persons admitted to the hospital for treatment or tests. For the purposes of this project, the patients described will be all over 60 years of age. In dealing with descriptive data about patients, "sex," "race" and "religion" are self-explanatory. "Age" is noted in five year intervals between 60 and 90 years. "Address" refers to the area in which the patient resided prior to hospital admission. "Diagnosis" refers to the condition or disease entity for which patient was admitted by the physicial to the hospital. "Unit" denotes that nursing area on which the patient received care. There were six different units on which patients could be placed, including one "Post-Intensive Care Unit" and one "Post-Cardiac Care Unit." Whether the patient had a "private duty nurse" as well as hospital staff involved in his care is also used in describing the patient. Data on patients included judgment about "amount of visiting" he had from family or friends, what his "plan at

discharge" was, and "length of time" he was actually a patient in the hospital.

Nurses refer to all R.N.'s and L.P.N.'s who are responsible for direct patient care. A Head Nurse is that R.N. who is in charge of the unit and has ultimate responsibility for what goes on there. An Aide is a person who has no nursing license but who participates in patient care by helping to bathe, feed and prepare patients and their rooms.

Physician refers to all the medical doctors who have patients hospitalized at White Plains Hospital. This term includes doctors of both sexes, variety of age and experience groups, variety of specialties and time spent in the hospital.

Family is used to describe anyone related to patient by blood or marriage. This would include spouse, parents, children, siblings, nieces, nephews, aunts, uncles, etc.

As can be seen from the definitions above, the "program" is made up of a variety of parts and participants, all of which contain a multitude of independent variables. Any one or several of the independent variables thus described, can effect outcome measures of the goal.

Definition of dependent variables

Dependent variables are those which are subject to change because of the operation of the program. These are here gross measures

of whether the goals of the program were reached. The following definitions will more closely define terms related to the dependent variables.

Linkage function is that area of service which fosters connections between patient and hospital, patient and community and patient and family. This is operationalized by a variety of measures derived from assessments of how patients view the service they have received, how social workers view the service given, how nurses and physicians assess the service as it was provided, and how the counselor-assistants felt about working toward provision of that service.

Such measures were obtained by rating answers to a number of "consumer satisfaction" questions which were put to the variety of participants.[4] Patients were asked if they were aware of having been visited by a counselor-assistant and were asked to rate the "helpfulness" of the counselor-assistant via a variety of tasks the counselor-assistant could have performed. If the counselor-assistant was seen as very helpful in one or more areas, a linkage function for the patient could be said to have been met.

Physicians and nurses were asked to assess program operation. If they saw the counselor-assistants as helpful to patients they were seen as suggesting that the linkage function was carried out. The social workers were asked to rate the ways in which the counselor-assistant was helpful to the patient, to the social worker and to others. By rating and combining scores on each item to reach a total "helpfulness score," the degree of carrying out the linkage function is thereby defined.

Questionnaires were also distributed to the counselor-assistants to provide some measure of their satisfaction with the program.

Thus, the "outcome measures" are subjective ratings of the usefulness of the service, of the comfort it provided and of the interest in seeing it continue. They are not empirically derived data based on systematically measured quantitative observables. In looking at the program, we will be describing it as objectively as possible and reporting on the subjective ratings given it by the participants. Because of the large number of independent variables which could effect the dependent, subjective ratings we can give a descriptive account of the ingredients in, operation of, and feelings about, this program. We can try to get some sense of which program elements may really ultimately effect outcome so that the program could be tried again in the future with an experimental design built in to more truly evaluate effectiveness.

Method

The investigation into this program used a survey design. The dictionary defines "survey" as a "critical inspection, often official, to provide exact information; often, a study of an area with respect to a certain condition, or its prevalence."[5] The condition we are studying in this evaluation was a kind of "consumer satisfaction." This was based on the assumption that satisfaction" or "contentment" specifically around program elements would occur if linkage functions were carried out.[6] Because "consumer satisfaction"

could occur or not depending upon variables other than that "product" or "program" "consumed," such investigation is surely not definitive. Rather, the surveys employed here will be suggestive of trends and elements which operate in the implementation of a new service.

Kerlinger defines "survey research" as "that branch of social scientific investigation that studies large and small populations (or universes) by selecting and studying samples chosen from the populations to discover the relative incidence, distribution, and interrelations of sociological and psychological variables."[7] We have discussed earlier, the characteristics of the counselor-assistants, or givers of the new service. As we try to look more objectively at the program, here, we will report on characteristics of the receivers of the service--the hospital patients. We will also be looking at some of the "sociological and psychological variables" which measure the satisfactions of a variety of participants in the program.

In a survey, personal interviews and questionnaires are among the ways that information can be obtained.[8] Structured interview forms and questionnaires were the instruments used here,[9] as well as forms on which to compile demographic data on patients. The following will describe the method of data collection from each group.

Data Collection

Data were collected from patients, doctors, nurses, social workers and counselor assistants to facilitate an evaluation of the program.

Counselor-assistants

At the end of the three-month pilot period, questionnaires were distributed to each of the seven counselor-assistants. (See Appendix L.) This was an attempt to assess more objectively, how each counselor-assistant felt about the program, what the rewards and frustrations of participation were, what suggestions for change they had and what their overall assessment was of the program. The counselor-assistants received these at a group meeting in order to go over the questions collectively and avoid misunderstandings. They then each completed the questionnaire alone at home and returned them the following week.

Physicians

Questionnaires were constructed for physicians to assess their awareness of and reactions to the program. (See Appendix K.) Physicians were asked if they knew of the program, if any of their patients were involved, how they felt it helped or didn't help their patients, etc. These questionnaires were distributed during the last week of the pilot project to 36 physicians in a "catch as catch can" sampling method. It was decided that while this is generally not a method of choice for sampling technique, in this situation, it would at least tap responses from physicians who are generally in the hospital at the same time as the program was in operation. There was an attempt made to administer the questionnaire to both physicians who had had patients receiving counselor-assistant visits and those who had no such patients. There was a representation of specialties, ages,

levels of experience, depth of relationship with patients, etc., as every physician available during the time period was asked to participate.

I would find the doctor on the unit, in the coffee shop or in the halls and request short meeting. During this time, I explained what I was interested in and asked that they fill out the questionnaire. Not one physician asked, refused. The responses of the variety of physicians were so similar as to make further distribution redundant.

Nurses

The same questionnaire given to the doctors was given to the regular day head nurse on each of the six units of the hospital. This was to assess their awareness of the nurses as to the existence of the program and to gain objective data with respect to their feelings about the program. Informal interviews with other nurses on the units gave responses consistent with impressions of the head nurse. However, data on "satisfaction of nurses" was compiled only from the formal questionnaire responses.

Social workers

The staff social workers were asked to rate the performance of the counselor-assistant with whom they worked on his or her performance with each patient seen. This was done by using prepared forms to check off ratings and comment on where improvements could be made. The forms were completed after the patient left the hospital and then

returned to me for compilation. The forms were pretested with social workers prior to their using them to rate the counselor-assistants. Instructions on completing them were given to the staff together to minimize individual differences in scoring. Informal discussions with staff contributed to the overall assessment process, as well.

Patients

Data on patients was compiled in two ways. Demographic data was obtained by the counselor-assistants who filled in such information on prepared forms. They were able to obtain such data both from patients' admission slips and from interviews with the patient. Counselor-assistants also kept records on prepared forms of their activities with and for patients and the dates on which these occurred. Both the patient and activity data were given to me when the patient was discharged from the hospital.

To assess the "consumer satisfaction" among patients, a form for a structured interview with the patient was constructed. A volunteer, uninvolved with the project, was recruited to do these interviews to minimize bias. This person who was selected to speak with patients was a 37-year-old married, mother of three, who had recently enrolled in a part-time social work program and was interested in helping to assess the program. I discussed the philosophy and method with her, of interviewing patients and recording their responses.

Since it was impossible to obtain responses from each patient involved in the program because of time, varying days of discharge, involvements in treatments, etc., it was decided to take a sample. The volunteer evaluator came in on random days and interviewed each patient

assigned on those days. The assignments were based on which patients were currently being seen by a counselor-assistant and had not been interviewed before. Such a method had the problem of responses being given by patients who might have seen the counselor-assistant only once and have one impression which when he or she saw more of the counselor-assistant could be changed. Ultimately, 54 of the 132 patients were actually interviewed by the volunteer evaluator.

Other hospital personnel

Informal discussions held periodically with the hospital administrator, director of volunteers, head of physical therapy and patient representative produced data also of interest when studying this program.

Method of Data Analysis

Two methods of data processing were used to sumamrize the information collected for analysis. Data collected from the doctors, nurses and counselor-assistants were processed by hand tabulation of their questionnaire responses. The more extensive data collected for each patient via information sheets of counselor-assistants, rating sheets of social workers and interview sheets of patients were coded, keypunched on IBM cards, and then processed by computer to compile descriptive statistics for analysis. The five percent level for statistical significance was employed where appropriate to facilitate the making of decisions about differences between groups or associations

among the data that could not have occurred by chance and therefore could be attributed to action taken in the counselor-assistant program.

Results

Physicians reaction to the program

Results. Responses to the questionnaire (see Appendix K) administered to 30 physicians who regularly attend patients at White Plains Hospital revealed that there was awareness of the program in only four cases. Two of these physicians were personal acquaintances of the project director who had heard about the program in a variety of contexts and the two others were the Chief of Staff and the Medical Director who had originally given permission for the operation of the program.

One-half of the respondents, while saying that they did not know if their patients had seen counselor-assistants or if the service was useful, did volunteer the information that they thought such a program in principle sounded like a good idea.

Discussion. From the data, it becomes clear that the physicians were unaware of the new service offered by the social service department. The attempt made via discussions with the medical director and committee to communicate about the new service was ineffective in dispersing information of the program to the attending physicians. Even informal discussions with specific physicians, seeking input and support at the outset did little to sensitize physicians to the fact that some of their patients would be seen by counselor-assistants.

Initial support was given, just as there was almost universal support for the concept even while the program had already begun, but upon questioning, they did not know that the service was operative. This was true, even in those cases where the social worker had noted in the chart that a patient was being visited by a counselor-assistant.

It is not surprising that physicians working with private patients in the community hospital would not be aware of all the services received by the patient in the hospital. The physician has the main responsibility for helping the patient to get well and even for helping to initiate discharge planning. Thus, the doctor will generally relate to the patient around issues of the patient's illness, physical concerns, and progress. The patient would not report to his physician that he or she had a special visitor. Thus, the physician would not learn of the counselor-assistant from the patient. Seeing such information in the chart ought to alert the doctor, but since he does not need to do anything to obtain such service nor to complete any forms or become involved, such information is not imperative to his goals and therefore quickly forgotten. During his rounds, the physician is unlikely to even see the counselor-assistants who will always visit patients when their doctors are not with them.

Nurses evaluation of the program

Results. The same questionnaire administered to the physicians was given to the six day head nurses. Prior discussions with other staff nurses revealed enough congruence of opinion as to render ratings given by only the head nurses as reliable indicators of the general attitudes of nursing staff toward the program.

All of the six nurses were aware of the program, had had contact with the counselor-assistants and felt that the counselor-assistants had been helpful to patients on their units. One head nurse wrote, "The counselor-assistants have helped to provide a person-to-person approach to older patients who might otherwise not have anyone to identify with over a prolonged hospital stay." Another felt that the counselor-assistants "are finding out many problems of patients and filling an emotional need of the patients." Other comments showed that the nurses felt the patients' needs were picked up and shared with social workers and nurses. Thus, they saw the counselor-assistants as performing a useful "linkage" role. They also noted that these special volunteers gave time and extra interest in the patients seen.

The questionnaires indicated that all of the six nurses felt that the counselor-assistants were helpful and that patients whom they saw generally experienced "less fear, disorientation or feelings of isolation than other comparable patients not having this service." The head nurses had no questions about the program and all commented that it seemed to be functioning well.

Discussion. Responses of the nurses clearly indicate their awareness of and interest in the counselor-assistant program. They are on the units all the time that the counselor-assistants come in to see patients. They are the primary care givers to patients and as such are aware of small changes in patients and in all the services offered to them.

Careful preparation of nursing staff was made prior to implementing the program. This was important in setting the scene for a positive reaction to the new service. Each counselor-assistant had been introduced to the head nurses with whom he or she would work. Each counselor-assistant made an effort to form relationships with the nurses on their floors. This attention to the details of relating to the nurses as well as those concerned with helping patients allowed them to be clearly visible. In this way, the positive response from nursing was made possible.

Counselor-assistants evaluation of the program

Results. As may be recalled, a questionnaire was given to each of the seven counselor-assistants to assess their feelings about the program. (See Appendix L.) They were asked to respond to questions about their enjoyment, frustrations, rewards and suggestions in the total program and in some of its parts.

Rewards. All of the counselor-assistants stated that they enjoyed working in the program. Being able to help others was the thing mentioned as the most pleasant aspect of the program for them. Other rewards of participating in the program which were mentioned were meeting new people, learning, working with the social work staff and being part of a group.

Frustrations. In answer to the question about what things made working in the program most difficult, five out of seven felt it was the fact that because of hospital routines, patients were not

always available to be seen. Parking was mentioned by four as a particular frustration and two spoke of problems with emotional involvement or identification with patients. One female counselor-assistant felt that seeing male patients in a state of undress was particularly distressing to her.

Definition of counselor-assistant. Each saw the role of the counselor-assistant as a variation on the theme of someone who is trained to visit patients and to listen, help with problems and connect patients to appropriate hospital staff persons or community resources under the direction of the social workers.

Training. All seven counselor-assistants felt that the training program had been useful in helping them to perform their role. They mentioned discussions on how to work with patients and input on community resources as particularly helpful.

Supervision. They all saw supervision as providing them with a back-up for problems they could not handle, as well as a mechanism to get and give information about patients. Three respondents felt that they learned how to understand and deal with patients better in their supervision. Five of the counselor-assistants felt their supervision did not need improvement. Two of the counselor-assistants would have liked the social worker to have been able to give more time to supervision.

Group meetings. The counselor-assistants all stated that they enjoyed the group meetings. They felt that sharing experiences and discussing techniques was helpful. Several suggested that the development

of comraderie was a positive outgrowth of these meetings. Suggestions for improvement of the group meetings included spending less time on cases and more in guest lecturers, as well as having more time overall for such group discussions.

Other hospital staff. Five counselor-assistants felt that other hospital staff was helpful in giving information and that they were pleased with the job that the counselor-assistants were doing. These latter two counselor-assistants happened to both work on the same units.

The patients. The counselor-assistants all felt that what the patient derives from the service they give is someone who listens and is really interested. The counselor-assistants feel that the patients enjoy the visits and are often cheered by them, as well as having someone near the same age and "specially trained" to help.

Opinion of program. When asked to give their opinions of the program, all the counselor-assistants felt it was very worthwhile and ought to be continued. Several stated that other hospitals ought to do it, too. Three of the counselor-assistants felt their service helped patients feel less fearful and disoriented. It must be noted, that the expression of all these positive feelings might have been influenced by the fact that the questionnaires were being returned to and collated by the program director.

Discussion. What we see, generally, from the responses to the questionnaires, are a group of people who are basically enjoying what they do. All of the counselor-assistants felt that they were

serving a very useful purpose and were secure in the knowledge that the social workers and patients felt grateful to them. Except for two, the counselor-assistants saw the nurses as appreciating their work as well.

While there are the specific frustrations of having to go back to see particular patients because they are unavailable when the counselor-assistant first comes, or the lack of parking facilities, the counselor-assistants feel very positively about their overall experience.

Subjective, spontaneous comments like, "I feel years younger" or "I love to get up on the mornings I come here" are corroborated by the responses to the questionnaires. It is clear that the people who were interested in the particular volunteer work and selected to do it, are deriving a great deal of pleasure and stimulation from it. They are helping others, and receiving gratitude, companionship and new skills and knowledge themselves.

Yet, one of the difficulties mentioned by only two counselor-assistants should be more fully discussed. One counselor-assistant spoke of having some problems with emotional involvement and another with identifying with patients. The other counselor-assistants were not in touch with such feelings, but the possibility for difficulties in this area remains. One of the counselor-assistants actually reported having dreams several nights in succession in which she was being attacked by some unknown force. She awakened with anxiety, following a warning call in her dreams to "look out." This counselor-assistant told of her dreams after she had already realized how they had a threat in common and how probably they were related to all the

illness and misfortune she saw in her days at the hospital. Her own insight led to a cessation of these dreams and her ability to share the experience with me. This very graphically illustrates the strong reaction that participation in such a program can cause.

Even with the realization of the anxiety she felt in relation to seeing patients, this counselor-assistant felt it could be dealt with because her rewards were even greater. The very real danger of such identification developing must be understood when undertaking such a program. It leads to the conclusion that selection of people capable of handling such problems is important. Also imperative is providing mechanisms to recognize and deal with such feelings. It is very possible that the very counselor-assistants who do not seem to be suffering with these feelings may be, instead, experiencing problems in other areas because of them. When a hospital social service department provides the service of counselor-assistants to older patients, it must also provide service to the counselor-assistants to help them particularly with problems around over-identification and constant exposure to vulnerability.

Description of Patients Who Received the Service of a Counselor-Assistant

In order to obtain an overview of the 132 patients who were seen at least once by a counselor-assistant during the pilot phase of this program, descriptive information was collected from several sources. Demographic information for each patient was obtained from forms filled out by the counselor-assistant in addition to information on admitting diagnosis, length of stay, unit in which stay occurred, plan at

discharge and counselor-assistant and social workers assigned.

A description of the patients using these data follows.

Results

Sex. The majority of the patients seen were female. There were 58 males and 74 females represented in the patient population served under this program.

Such a distribution is representative of the general population over 60 years of age where women outnumber men; yet, it could also indicate selective assignment of the counselor-assistants to female rather than male patients.

Age. The ages of the patients ranged from 60-94 years. The mean age group was between 70 and 80 years but the age groups with the largest number of participating patients were 80-84 and 65-69. (See Table 1.)

TABLE 1

AGE GROUPS OF PATIENTS SEEN BY COUNSELOR ASSISTANTS

Patients	Age Groups of Patients						
	60-64	65-69	70-74	75-79	80-84	85-89	90-94
Number	18	25	23	18	26	15	7
Percentage	13.6	18.9	17.4	13.6	19.7	11.4	5.3

Ethnic groups. The patients served were predominantly white, 119 patients being white and only 13 who were black. The communities that White Plains Hospital draws from are predominantly white.

Religious background. The largest number of patients, 56 were Protestant, while 46 were Jewish. Of the remaining, 29 were Catholic, one was Christian Scientist, and one was unknown. (See Table 2.)

TABLE 2

RELIGIOUS BACKGROUND OF PATIENTS SEEN BY COUNSELOR-ASSISTANTS

Patients	Religion				
	Protestant	Jewish	Catholic	Christian Scientist	Unknown
Number	56	45	29	1	1
Percentage	42	34	21	1	1

Admitting diagnosis. When looking at the data, it was found that 40 or almost 33 percent of the 132 patients had been admitted for some type of heart disease or related condition. This is not surprising when we realize that heart disease accounts for 40 percent of the deaths among people over 45 years of age.[10] Fractures caused hospitalization for the next largest group of 26 patients. (See Table 3.)

Units housing patients. Patients were seen in units throughout the hospital. The highest concentration of patients turned out to

TABLE 3

DISEASES FOR WHICH PATIENTS SEEN BY COUNSELOR-ASSISTANTS WERE ADMITTED TO HOSPITAL

Patients	Type of Disease									
	Stroke	Heart Disease	Can-cer	Dia-betes	Thrombo-Embolism	Arthritis	Fracture	Urinary Problems	Pneu monia	Other
Number	8	40	8	11	3	4	26	5	2	25
Per-centage	6.1	30.3	6.1	8.3	2.3	3.1	19.7	3.8	1.5	18.9

be on 4F, that unit which is exclusively for cardiac care. (See Table 4.) The smallest number were on 6F which was the one unit that was closed for much of the time that the project was in its pilot phase. Of the patients seen, only five had private duty nurses. These were generally more severely ill or incapacitated.

TABLE 4

HOSPITAL UNITS ON WHICH PATIENTS WERE LOCATED

Patients	Hospital Unit					
	3F	4F	4E	5F	5E	6F
Number	24	34	15	27	28	4
Percentage	18.2	25.8	11.4	20.5	21.2	3.0

Visiting. The patients at White Plains Hospital generally had visitors. Only 17 were seen as having no one who came to see them in the hospital. Fifty-six patients were noted to have some family and friends visiting and 50 had much of such visiting. White Plains Hospital is a community hospital and as such, draws on a population that generally is rather close by. It is readily accessible by car and bus.

Length of hospital stay. The length of stay varied for patients, but the average was between 16 and 25 days. This appears to be over the 12.1 day average stay of those over 65 years reported by the

U.S. Department of Health in 1975.[11] There was a normal distribution of patients with those making up almost all the cases, found clustering in the categories of staying 11-15, 16-20, 21-25 or 26-30 days. (See Table 5.)

TABLE 5

LENGTH OF PATIENTS' HOSPITAL STAY

Patients	Days Patient Stayed in Hospital									
	0-5	6-10	11-15	16-20	21-25	26-30	31-35	36-40	41-45	Over 45
Number	4	8	19	18	23	21	11	8	7	13
Percentage	3.0	6.1	14.4	13.6	17.4	15.9	8.3	6.1	5.3	9.9

Discharge plan. At the end of the acute phase of a patient's illness, a variety of discharge arrangements could ensue. (See Table 6.) Most patients, 55, went back home by themselves or with family, into the arrangement that they had prior to hospitalization. The next largest group of 32 patients was discharged to nursing homes, generally as a new permanent living situation. A large group of 27 went to the rehabilitation hospital. Frequently, patients who had sustained fractures had cardiac problems or strokes were treated further and helped to regain more function at a rehabilitation facility following diminution of the acute phase of their illness.

TABLE 6

PLACE TO WHICH PATIENT DISCHARGED FROM HOSPITAL

Patients	Discharge Plan						
	Home: Self/ Family	Home With Help	Rehabilitation Hospital	Nursing Home	Other Hospital	Home of Friend	Died
Number	55	9	27	32	2	2	5
Percentage	41.7	6.8	20.5	24.2	1.5	1.5	3.8

Profile of average patient

In summarizing the characteristics of the patients one can draw a profile of the average patient served in the counselor-assistant program. Such a patient would be a white, Protestant, female between 70 and 80 years old, coming from White Plains. She would be suffering from heart problems and likely to be on the cardiac care unit. After treatment lasting about 20 days, she would return home to the same living arrangements from which she had come. During her hospital stay she would not have had private duty nurses but would have had visits from family and friends.

Use of information on patients

The foregoing descriptions of patients are useful in obtaining a picture of the kind of patients who were seen by the counselor-assistants. Later in this chapter, scores of "helpfulness of counselor-

assistants" given by the social workers will be looked at as they are compared between groups of patients using these areas of differences.

Description of Program Implementation

Another dimension of program operation was the number of patients participating in the program who were seen by each counselor-assistant and who were known to each social worker. The following will provide this information.

Counselor-assistants who saw patients

The number of patients seen by each of the counselor-assistants varied from 13-27. (See Table 7.) A variety of reasons exist for the discrepancy in numbers. Counselor-assistants who never missed a day would be able to see more patients than those absent now and then. Individual differences among patients and how much or freely they would converse, influenced the total possible to have been seen. The interest and style of the counselor-assistant was another factor determining overall number of patients seen. General efficiency and competence of the counselor-assistant could lead to increased numbers of patients seen, while giving more time or handling more areas of concern for each patient could decrease overall numbers.

Social workers involved with patients being seen by counselor-assistants

The numbers of patients seen by counselor-assistants for whom each of the four social workers had responsibility varied. (See

TABLE 7

NUMBER OF PATIENTS SEEN BY EACH COUNSELOR-ASSISTANT

Patients	Counselor-Assistant						
	VB	LG	RK	MM	FN	LW	AY
Number	13	17	13	18	27	20	24
Percentage	9.9	12.9	9.9	13.6	20.5	15.2	18.2

Table 8.) The two full-time social workers (MQ and VA) each has two counselor-assistants working with them, while the part-time worker (SB) had three counselor-assistants to whom to assign patients. The variation in numbers here, reflects this distribution as well as the ability of the individual counselor-assistants to see numbers of patients. CH was the vacation relief worker who had many fewer patients on whom she evaluated the work of the counselor-assistants.

TABLE 8

NUMBER OF PATIENTS FOR WHOM EACH SOCIAL WORKER HAD RESPONSIBILITY

Patients	Social Worker			
	SB	MQ	VA	CH
Number	40	30	42	20
Percentage	30.3	22.7	31.8	14.3

Social Worker Evaluations of the Counselor-Assistants

The social workers were asked to complete forms for each patient rating the helpfulness of the counselor-assistants on a number of items. (See Appendix J.) The ratings could be "detrimental," "not helpful," "made no difference," "somewhat helpful," and "very helpful." Because at no time was any counselor-assistant rated below "made no difference," we looked only at the notation of "made no difference," "somewhat helpful" or "very helpful" in analyzing the data.

The first group of items related to areas that would be of help to patients. Only in the area of providing companionship to the patient was there overwhelming evidence of helpfulness. In 31 percent of the cases, counselor-assistants were somewhat helpful in this, whereas 62 percent were very helpful. Providing continuity for patients was seen as an area in which slightly more patients were seen to have received help (29 percent, somewhat, and 42 percent, very much) than those to whom the service made no difference (61 percent). Table 9 will illustrate the figures.

Items like accompanying patient to other parts of the hospital or helping patients with forms showed clearly that the counselor-assistants made no difference to patients in these areas. Although these were initially tasks that the counselor-assistants were expected to perform, in actuality, there was little need for the counselor-assistant to help with forms and seldom the coincidence of the counselor-assistant visiting at the same time that the patient would have to be taken to another part of the hospital. Ratings of the social workers showed several areas where about half the time patients received

TABLE 9

SOCIAL WORKER RATINGS OF COUNSELOR-ASSISTANTS - HELP TO PATIENTS

Areas of Help to Patients	Percent of Patients For Whom These Ratings Given		
	No Difference	Somewhat Helpful	Very Helpful
Provide companionship	6	31	63
Orient patient	58	20	22
Accompany patient	92	5	3
Alleviate depression	54	22	24
Alleviate fears	53	21	25
Provide continuity	46	22	32
Help with forms	98	1	1
Other	92	2	6

help. In orienting the patient to hospital routines, alleviating depression and fear, the percentage who made no difference is almost equal to those who provided at least some help. These are difficult assessments to make and the outcomes in these are related to so many other variables that we can make no definitive statements about them.

Help to social worker

Social workers were asked to rate the counselor-assistants on how helpful they were for the social worker, in specific areas. In the area of speaking with patients an overwhelming 67 percent were seen as

very helpful, with 30 percent seen as somewhat helpful, while only three percent made no difference. In the one other area of speaking to hospital staff, while 67 percent made no difference, 23 percent were seen as very helpful. (See Table 10.)

TABLE 10

SOCIAL WORKER RATINGS OF COUNSELOR-ASSISTANTS - HELP TO SOCIAL WORKER

Areas of Help to Social Workers	Percent of Patients For Whom These Ratings Given		
	No Difference	Somewhat Helpful	Very Helpful
Speaking with patient	3	30	67
Speaking with family	89	8	3
Speaking with staff	67	10	23
Contact doctors	97	1	2
Contact community agencies	89	2	8
Complete forms	97	1	2
Other	98	1	1

These data show that the counselor-assistants were most helpful in speaking to patients and providing direct service. They were seen as helping somewhat with liaison to hospital staff, but generally not with doctors, families or community resources. This follows the premise that the social worker is always the representative of the

hospital or patient when conferring with outside professionals. While the counselor-assistants did often seek information or gather data, the social workers maintained ultimate connections with doctors, families and agencies and therefore did not view the counselor-assistant as needing to provide help in these areas.

For whom was the counselor-assistant helpful?

The social workers were asked to assess if counselor-assistant help was provided to the patient, his family, nurses, doctors, the goals of the hospital or others. Social workers clearly saw the counselor-assistant as helpful to the patients, but not to families. About one-fifth were very helpful to the nurses and to the goals of the hospital, but generally the social workers did not see the counselor-assistants as having made a difference to these groups. (See Table 11.)

In all of the assessments by the social workers, what emerges clearly is how "helpful" they thought the counselor-assistants were to the patients and to themselves in dealing with patients. Specific areas of help which were thought to be those the counselor-assistant could give proved not to be. There could be many reasons for this. One strong possibility is that the patients seen did not have some of the needs the counselor-assistants were supposed to fill. Help with forms was not something most patients needed. Orientation to hospital routines was often accomplished earlier in patients' hospitalization. Thus, by the time the counselor-assistant was assigned to a patient, the patient who had been in the hospital for some time had already learned much about the hospital.

TABLE 11

SOCIAL WORKER RATINGS OF COUNSELOR-ASSISTANTS - HELPFULNESS TO OTHERS

Help Given to These Groups	Percent of Patients For Whom These Ratings Given		
	No Difference	Somewhat Helpful	Very Helpful
To patient	13	27	60
To family	90	5	5
To nurses	76	5	19
To doctors	97	2	1
To goals of hospital	77	4	20

The objective rating sheet assessment by the social workers must be looked at as one measure of their help. Included in such an assessment, must also be the social workers' reported opinions about the program. These were generally very positive expressions of the amount of help they were receiving from the counselor-assistants. "I don't know what I would have done without the counselor-assistant today." "The counselor-assistant was able to really spend time with Mrs. X who needed to talk." "I put in time with the counselor-assistants, but the service they provide, more than makes up for it." Generally there was good feeling about the service to patients and as a by-product, the help the social workers received.

There were also many pitfalls, however. Initially, particularly, the social workers had to give the counselor-assistants a great deal of

time. Allaying anxiety, going over routines, and supporting the work of the counselor-assistants was a rather taxing cost of providing an extra service. After the first month, such tasks became lighter for the social workers and the rewards of having an adjunctive service grew. Even where the work of the counselor-assistants was seen as less helpful, the total experience was seen positively. One social worker had two counselor-assistants who had trouble relating to illness and who did not pick up on problems. One of these fulfilled the role of companion beautifully. She was able to have long discussions with patients and so thoroughly enjoyed her encounters that the patients were delighted to have her come. In this case, the social worker learned to use this counselor-assistant in situations where the need was specifically to only have a companion. The other counselor-assistant was very good on detail and concrete tasks, but had difficulty dealing with emotions, both with the patients and with the social worker. In this situation, the social worker had to work with this counselor-assistant to establish a productive relationship with him and to help him with some of the frightened feelings aroused by his work. The social worker had to put in a lot of time and effort in working with this counselor-assistant, but felt very gratified in the gains he made and in her own growing skills in supervision.

Patient Evaluations of the Counselor-Assistants

Of the 132 patients who were seen by the counselor-assistants, as described earlier, we were able to obtain interviews with 54 patients. The following discussion is based on the interviews with these people.

Awareness of program

When questioned about whether they were aware of having been seen by a counselor-assistant, many of the patients were not familiar with this term. When the counselor-assistant was described or the name given, 50 of the patients clearly remembered their counselor-assistant. Four did not.

Times seen by counselor-assistant

When the patients were asked to judge how many times they had been visited by the counselor-assistants, most felt it had been a few times. (See Table 12.)

TABLE 12

PATIENTS' PERCEPTIONS OF HOW MANY TIMES THEY WERE VISITED BY COUNSELOR-ASSISTANT

Patients	Number of Times Visited				
	One	Few	Often	Very Frequently	Blank
Number	13	33	5	2	1

This can be compared in a general way with the number of visits to patients as reported by the counselor-assistants. (See Table 13.) One hundred two patients were seen from one to four times while only

TABLE 13

NUMBER OF VISITS TO PATIENTS AS REPORTED BY COUNSELOR-ASSISTANTS

Patients	Number of Visits									
	1	2	3	4	5	6	7	8	9	10+
Number	25	32	26	19	9	6	7	2	4	3
Percentage	19	24	20	14	7	5	5	2	3	2

30 patients were seen five or more times. There were an average of three visits to each patient.

Helpfulness of the counselor-assistant

When asked about how helpful the counselor-assistant was to them, patients generally felt the counselor-assistant provided friendly conversation, but did not credit the counselor-assistant as being helpful on the variety of tasks asked about. (See Table 14.)

From the data, we see that areas in which patients reported receiving the most help were those in which the counselor-assistant explained hospital routines, suggested community resources and gave information to decrease fears. Again, it appears that several areas which were originally conceived of as needs, were in practice not areas of concern. The patients reported that the counselor-assistants did not accompany them to other parts of the hospital, did not write letters for them, did not speak to their families and did not help with

TABLE 14

PATIENTS' PERCEPTIONS OF THE HELPFULNESS OF THE COUNSELOR-ASSISTANT

Areas of Help to Patients	Number of Patients Who Report Degree of Helpfulness				
	Very Helpful	Somewhat Helpful	Combined	Not Helpful	Blank
Friendly conversation	43	5	48	5	1
Explained hospital routines	4	11	15	38	1
Brought needed items	3	3	6	47	1
Made calls	4	4	8	45	1
Accompanied to other areas	0	1	1	52	1
Helped with forms	1	2	3	50	1
Spoke with family	6	5	11	42	1
Suggested resources	11	6	17	36	1
Gave information - decreased worries	8	11	19	34	1
Read or wrote mail	1	1	2	51	1
Other	6	1	7	46	1

forms. This corroborates with the perceptions of the social workers, as given earlier.

In looking at this data as obtained by structured interview, we must be aware of the fact that we are dealing with a population that

generally reports self-sufficiency. To say that one has received help is to admit that help was, in fact, needed. This is often difficult to admit, even to oneself, and should be kept in mind when examining such data. This may be further confirmed by the 41 patients who felt that there was no other type of help that the counselor-assistant really could have given them.

When asked if the program should continue, 51 patients felt that it should, two did not answer and only one felt that it was unnecessary and could be terminated. The reasons given by patients for continuation were that it is good, it helps people, and it makes the hospital stay pleasanter.

In general, the patients interviewed felt positively toward the program. They enjoyed speaking with the counselor-assistants and in many cases reported having received specific kinds of help from them. The fact that many felt the counselor-assistants were a helpful adjunct to their stay showed a positive trend. The fact that the program was new, unexpected by patients and that counselor-assistants often saw patients late in their stay were elements decreasing the impact that any counselor-assistant could have on patients. The small number of actual visits with patients may have contributed to the lack of very demonstrable impact that the program had on them.

Interrelationship of Descriptive Variables with Assessments Made by the Social Workers of the Helpfulness of the Counselor-Assistants

Outcome measures

In trying to compare descriptive variables with performance of the counselor-assistants, there was an attempt made to produce some measure of helpfulness from all the ratings collected. In order to do this, several ratings had to be combined into a score. Responses were weighted, one point for a mark in the "somewhat helpful" column, and two points for each check in the "very helpful" column. Scores were developed for each area dealing with items that "helped the patient," "helped the social worker" or "helped others." The total of the three scores was the overall "performance score" for that counselor-assistant with the patient. (See Appendix J for the questionnaire for social workers.)

The scores for each section could vary as follows:

Minimum Score would be 0 and would show that the counselor-assistants had made no difference on the items.

Maximum Scores varied with each of the areas:

Area	Maximum Score
"Help to Patient"	16
"Help to Social Worker"	14
"Help to Others"	10
"Index of Performance"	40

After tabulating all the "helpfulness" scores for the counselor-assistants as given by the social workers, we can derive the

mean score given for each area. The mean score for "help to patient" was 4.9, for "help to social worker," it is 2.8, and for "help to others," it is 2.7. The total "performance score" has a mean of 10.4.

It is expected that the mean scores are considerably below the possible high scores because of the numerous items on which the counselor-assistants really provided no service. (See earlier discussion of ratings by social workers.)

While we are aware that in this pilot project, there can be no definitive trends shown, we were interested in looking at whether any variation among patients with regard to the descriptive variables, seemed to have any effect on the outcome variables (combined scores). Mean index scores were compared on each variable for selected characteristics of patients, using one-way analysis of variance.

Address at admission and age. Using this method, it was found that where the patient came from had no effect on any outcome scores. Age had some effect but the differences were not significant. There was data to show that patients 60-64 years old had the highest mean scores of being helped and those 90-94 years old had the lowest. A trend is shown in which helpfulness is decreasing with advancing age. (See Table 15.)

Sex. A difference in how males and females were seen as being helped, appears to be significant ($p = .003$). Females seemed to have received more help than males. (See Table 16.)

Whether females generally needed more help because of perhaps greater mean age, or more of them living alone, is not known, but could explain these findings. It is also possible that the female patients

TABLE 15

COMPARISON OF MEANS OF PERFORMANCE RATINGS
BY AGE GROUPS

Age of Patient	Mean Performance Score[a]
60-64	14.500
64-69	10.160
70-74	11.304
75-79	9.944
80-84	8.654
85-89	9.667
90-94	7.286

[a]F test = 1.099; 6 df; p = .367

TABLE 16

COMPARISON OF MEANS OF SCORES FOR MALES AND FEMALES
IN HELPFULNESS RATINGS

Area of Help	Sex	Mean Index Score	Level of Significance
Help to patient	Male Female	3.67 5.91	F test = 9.68, 1 df p = .003**
Help to social worker	Male Female	2.80 3.20	F test = 5.87, 1 df p = .017*
Help to others	Male Female	1.90 3.30	F test = 11.38, 1 df $p < .001$***
Performance score	Male Female	7.90 12.40	F test = 9.82, 1 df p = .003**

studied were more receptive to help than the males. The fact that the females were seen as having received more help as judged by all female social workers could also play a role in explaining this particular finding. It was also shown in the analysis that females were seen significantly more times than males. This too could increase their chances for being helped.

Race, religion, diagnosis at admission. Race, religion and diagnosis at admission had no discernable effect upon outcome scores.

Hospital unit. It is interesting to note that the differences in hospital unit produced some mean scores in performance that differed significantly. Significant differences were also found in the areas of "help to social worker" and "help to others" scores. (See Table 17.)

TABLE 17

DIFFERENCES IN MEANS OF GROUPS ON HOSPITAL UNITS WITH RESPECT TO "HELP TO SOCIAL WORKER" SCORES

Hospital Unit	Mean Index Score[a]
3F	4.1
4F	2.5
4E	1.7
5F	1.8
5E	3.4
6F	3.0

[a]F test = 4.65; 5 df; $p < .001$***

Such differences between groups on units are maintained for each of the four outcome scores. At first glance, such variability is surprising. Yet, when this result is put together with the fact that the two counselor-assistants who have received the lowest scores are the two who were working on Units 4E and 5F, one finds a possible explanation for this finding. A particular social worker worked only on these units and her scoring may have been consistently low. The nursing staff on one of the units was particularly difficult and this could have affected the scores as well.

Private duty nurses and visitors. Whether the patients had private duty nurses did not affect how the counselor-assistant was rated as helping. Whether the patient had visitors seemed to show a trend where the counselor-assistant was seen to be most helpful where patients had no visitors. These differences were not statistically significant. (See Table 18.)

TABLE 18

DIFFERENCES OF MEANS IN PERFORMANCE SCORES BETWEEN PATIENTS WHO HAD NO VISITORS, SOME VISITORS AND MANY VISITORS

Pattern of Visits	Mean Performance Score[a]
None	13.8
Some	8.7
Much	11.1

[a]F test = 2.68; 2 df; p = .073

Discharge plan. When we look at the variable of where the patient went upon discharge from the hospital, again the differences between group means are not significant. The counselor-assistants were seen as most helpful to patients who returned home with some outside help. They were rated next highest in the group having to go to another hospital. (See Table 19.)

TABLE 19

DIFFERENCES OF MEANS IN PERFORMANCE SCORES BETWEEN GROUPS WITH A VARIETY OF DISCHARGE PLANS

Discharge Plan	Mean Performance Score[a]
Home	10.6
Home with help	15.4
Rehabilitation hospital	10.3
Nursing home	9.6
Another hospital	11.5
Home of friend	7.5
Died	6.4

[a]F test = 0.785; 6 df; p = .500

It is interesting to note that the group which went home with outside help was also a group seen most often. Both of these trends may be results of patients who are more incapacitated, yet with good prognosis, so they stay in the hospital longer to regain functioning

and are therefore around longer. This allows them to be seen more often by the counselor-assistant.

Length of stay. When comparing length of stay in the hospital to ratings given the counselor-assistants by the social workers, it is clear that those who stay 0-5 days are least helped and those who stay over 45 days most helped. The great variability for all the length of stay ranges between makes this correlation not statistically significant.

What do appear statistically significant are the means of comparisons between the ratings of helpfulness of each counselor-assistant by the social workers. The measures of all the ratings given by each social worker were also noted to be different not just by chance alone. (See Table 20 and Table 21.)

TABLE 20

MEANS OF PERFORMANCE SCORES OF EACH COUNSELOR-ASSISTANT

Counselor-Assistant	Mean Performance Score[a]
VB	12.8
LG	17.1
RK	11.1
MM	4.1
FN	14.5
LW	8.9
AY	5.4

[a]F test = 8.043; 6 df; $p < .001$***

TABLE 21

MEAN PERFORMANCE SCORES BY SOCIAL WORKER

Social Worker	Mean Performance Score[a]
VA	10.3
SB	4.8
MQ	15.3
CH	15.5

[a]F test = 15.145; 3 df; $p < .001$***

The social worker who gave the lowest performance score ratings was the one who worked with the two counselor-assistants who were seen as having the lowest ratings. In such a situation we could be dealing either with a person who consistently gives lower ratings or with a situation in which those rated were generally less helpful. The subjective data has to be imposed on the objective. It is the author's opinion that it was the latter situation which occurred and caused these scores to be particularly low.

Summary

In this chapter, we have indicated how a variety of groups assessed the services of the counselor-assistants. The physicians were unaware of the program operation, but stated agreement with its intent. Nurses were well aware of the institution of the program on their floors and appeared pleased with the effect of the counselor-

assistants on patients. The volunteers, themselves, reported receiving a great deal of satisfaction from participating in the program. They saw themselves as receiving useful input from supervision and meetings in order to perform a worthwhile role for patients. The social workers saw the counselor-assistants as being most helpful in talking to patients in order to provide companionship and special services. They did not feel that the counselor-assistants were helpful to patient's families, to the doctors or to community agencies, but felt they played some role in liaison with the nurses. Social workers were well aware of the extra time needed to supervise the counselor-assistants, particularly in the beginning of the program. Attention must be paid to the problems of over-identification with patients which can occur.

In describing the characteristics of the patients who received service from counselor-assistants we see that most of the patients are white, female and Protestant. Average age was between 70 and 80 years and 30 percent were admitted with diagnoses of heart problems. Patients generally had visitors, but not private duty nurses. They stayed in the hospital on the average of between 16 and 25 days and upon discharge, most often returned to the living situation from which they had come.

When comparing performance scores of counselor-assistants as rated by the social workers, some characteristics of patients seemed positively related to outcome. Helpfulness of the counselor-assistants seemed to increase as age level decreased from 94 to 60 years. Females were seen as receiving more benefit from counselor-assistants, and those patients who had no visitors seemed to derive greatest help from the counselor-assistants. Patients who were visited by certain

counselor-assistants were seen to have received more help than those visited by others.

Race, religion, diagnosis at admission, and discharge plan did not seem to affect outcome score as rated by the social workers.

From the data, it can be seen that performance scores were generally low. This may be due to the fact that a volunteer coming only two times a week and seeing patients an average of three times during their hospital stay may have little real impact upon patients. While subjective responses of both patients and social workers are that the counselor-assistants perform "a helpful and positive service," objective measures used here fail to show very high degree of helpfulness. The measures, themselves, may contribute to the low scores received overall by the counselor-assistants. The experience of this program showed that several of the items on which counselor-assistant activity was rated, were, in fact, not pertinent to tasks actually performed.

If this program were to be implemented again, further research under more controlled conditions could lead to better understanding of the operation of variables suggested here.

Footnotes

[1]Eugene B. Shinn, Lecture given in spring of 1973.

[2]Herbert Hyman; Charles Wright; and Terence Hopkins, Applications of Methods of Evaluation: Four Studies of the Encampment for Citizenship (Berkeley and Los Angeles: University of Colorado Press, 1962), p. v.

[3]Carol Weiss, Evaluation Research: Methods of Assessing Program Effectiveness (Englewood Cliffs, N.J.: Prentice-Hall, 1972), p. 2.

[4]See Appendices for copies of questionnaires given to social workers, counselor-assistants, doctors, nurses and patients.

[5]Webster's New Collegiate Dictionary, 2nd ed. (Springfield, Mass.: Merriam, 1949), p. 855.

[6]Because "linkage functions" were defined as specific tasks, the "satisfaction" with the services rendered could be seen as the "satisfaction" regarding the "linkage function."

[7]Fred N. Kerlinger, Foundations of Behavioral Research (New York: Holt, Rinehart and Winston, Inc., 1964), p. 393.

[8]Ibid., p. 395.

[9]See Appendices for copies of questionnaires for all the participants.

[10]Ethel Shanas and George Maddox, "Aging, Health and the Organization of Health Resources," Handbook of Aging and the Social Sciences, ed. by Robert Binstock and Ethel Shanas (New York: Van Nostrand Reinhold Co., 1976), p. 602.

[11]U.S. Department of Health, Health, U.S., 1975, Public Health Service, Health Research Administration, Department of Health, Education and Welfare Publication Number (HRA) 76-1232 (Washington, D.C.: Government Printing Office), 513, 573.

CHAPTER X

SUMMARY AND DISCUSSION

Meeting Project Objectives

The objectives of this project were met via the program described and the evaluation imposed thereafter. The project came about as an attempt to answer two important unmet needs of the aged in our society. One of these is the need for better treatment of older people in the acute care hospital. The other is the need for greater opportunity for the productive use of leisure time for the elderly. The underlying value for producing this project was that where people are denied access, special attention must be given to them to lead to more equality of opportunity.

A program was developed to answer these needs. As a basis for developing the program, the theoretical framework of Litwak's Typology of Organizations and Tasks was used. In addition, we took evidence identifying that older adults desire and can sustain interest and involvement in satisfying work when given the opportunity.

The theoretical basis for planning the program

In formal organizations, there is a need for the performance of uniform or technical, skilled tasks and non-uniform or those tasks for which ordinary experience is all that is necessary. In organizations with a high degree of specialization, these functions are

compartmentalized. One group is generally given the role of caring for non-uniform needs. In the hospital setting such tasks fall into the province of the social service department, the patient representative or the volunteer department. Efforts with children in this regard have been quite successful. Parents can sleep over, staff spends extra time, etc. For the older patient, however, attention to non-uniform needs has not been optimal. In order to effect change, this program was developed as a way of attending to "non-uniform needs," in a highly complex organization, specializing in the "uniform tasks" around illness.

It was felt that patient satisfaction would increase if some of his or her "non-uniform" needs were met. Service given by the hospital, it was postulated, would be better balanced if a new link in the form of the counselor-assistant were placed within the system. From the subjective information given by nurses and social workers there were indications that the theory is operative. Codified data show that the counselor-assistants' performance of the role of companion for the patient was one non-uniform task that was carried out and did contribute to patient satisfaction. In specific instances, with specific patients, a variety of other non-uniform tasks were performed and helped in the adjustment of these patients. There are, thus, indications that a better balance can be reached for older patients in an acute care hospital, if greater attention is paid to those needs, formerly cared for by the primary group and often left unattemded in the presence of such a now highly technical institution.

From the implementation of this program there are beginning indications of positive results. Creating a service to help to meet

some of the non-uniform needs for patients who are receiving help with the uniform ones already in the hospital, is both appropriate and possible. Seeing areas of difficulty in this program, certain modifications can be suggested to incorporate in any future program of this kind. These could lead to even greater performance of those non-uniform tasks so important to balance the technical ones performed in the hospital. Later in this chapter, several modifications will be discussed.

Use of the older adult to perform helping role in the hospital

In this project, we have seen, once again, the ability of older adults to perform most adequately in the service role. The people involved as volunteers sustained a high degree of interest, motivation and excitement for the length of the pilot project and long after. They brought attributes of ability to empathize, to be flexible and to learn, and were able to develop competence and comfort in performing the role of counselor-assistant. Each person who served as a volunteer reported stimulation and pleasure from participating in the program. High morale, raised self-esteem, renewed zest in life were reported by these older adults. They gave evidence for the theory that opportunities for productive use of time is a basic need in all adults.

The pitfalls of using such people as service-givers in the hospital must be noted here as well. There are the dangers for this group of overidentification with patients and increased anxiety, which cannot be overlooked. These do not negate the positive outcome

for older people having the opportunity to do this kind of work, but do point up a sign of caution to be considered before proceeding.

The Program Reconsidered

In summarizing what was actually attempted and accomplished in this project, we can look briefly at the steps involved.

Initially it was important to develop a receptive context in which to demonstrate the use of the older adult to provide a linkage function for older adult patients. The process involved in this has been described in the "initiation phase." It is important to realize how vital the process in this period was to the ultimate implementation of the program. When a new program is to be instituted into an ongoing institution, months of planning, informing, even politicking are imperative. Particularly in this situation, where we were dealing with a multidisciplinary institution, it was clear that involvement of each discipline in the early stages of the program development led to acceptance of the program. The receptive climate is paramount to program development, growth and survival. Involvement of the hospital administration, positive input from staff members in all disciplines and commitment of particularly the social service director and staff have to exist and form the basis on which the program is built.

A second stage was the development of a group of persons to provide the new service. This was a crucial part of the "implementation phase." Recruitment was difficult, particularly when seeking very special people to serve a very specific and time-consuming function. Principles learned here could be employed in the future, but recruitment of good volunteers remains a very particular problem.

Selection of people who met the criteria was also seen to be a very important part of the development of this program. When seeking people not just to "help," but to do specific tasks in a particular way, good initial selection is imperative. Attributes which were necessary to perform the role of counselor-assistant could be enhanced, but never added to the basic personalities of the volunteers.

Training the counselor-assistants for their role was a third and very important step in developing a cadre of people to provide a service. Techniques appropriate for adult learners were employed to impart knowledge, encourage attitudes and develop skills. Through this, the counselor-assistants developed familiarity with the hospital and the community. They became more skilled at interviewing and comfortable in working with patients in the hospital. They began to think of themselves as counselor-assistants, as part of a group and as an adjunctive service to the social services offered at White Plains Hospital.

Mechanisms had to be developed through which trained counselor-assistants were able to perform necessary non-uniform tasks for patients in the hospital. The structure of this program was the mechanism for the specially trained volunteers to provide their linkage function. The program structure included: (1) definition of their role, (2) expectation of how to work with patients, (3) individual supervision, and (4) group supervision.

1. <u>By trying to clearly delineate the role of the counselor-assistant</u>, the tasks this person was to perform were carefully outlined. It was most important for the social workers to have

responsibility for each case, to make judgments about the goals and interventions necessary and to supervise the actual work of the counselor-assistants. The conclusions reached here corroborate well with those of Farrar and Hemmy when they speak of the efficacy of using non-professional staff alongside professional social workers in helping the aged.[1] They suggest that careful definition of the non-professional role was paramount to success.

> The job of the non-professional worker was carefully defined as to scope, organization and qualifications. Criteria were formulated for tasks appropriate to the job. The title of "social services assistant" was chosen to emphasize the facilitative role and to differentiate it from that of the professional worker.[2]

Such careful description and differentiation of roles is necessary whenever utilizing non-professionals alongside professionals. Certainly in a multidisciplinary setting where several professions must work together, such clarity becomes even more urgent. Farrar and Hemmy also demand that "responsibility for defining goals and exercising judgment must remain with the professional social worker."[3] The conclusion reached after developing this program concurs with theirs. "It is quite possible to differentiate and coordinate the two roles of caseworker and assistant without confusing the client, family or people in the community."[4]

2. Expectation of <u>how the counselor-assistant was to work with the patients</u> was made clear as well. Friendly visiting was one part of the service they were to give. Interviewing, listening and collecting data were particular skills being developed in the program. Suggesting outside resources was another area of service. The resource book which each counselor-assistant had to use in helping link patients

with outside resources was another mechanism employed in their work with patients. The ability to empathize was mandatory for the counselor-assistant to have. Added to this, was the expectation of confidentiality regarding patients and an enthusiasm for helping, even with unpredictable and unusual needs of patients.

3. The individual supervision which each counselor-assistant had with a specific social worker was another important program mechanism through which the counselor-assistant could provide the linkage function. The counselor-assistant was able to learn about patients he or she was to see and to then report back on how the patient appeared to be doing, or what specific concerns were found. By the use of the social worker's judgment, the counselor-assistant would be directed to doing specific tasks or helping to draw the patient out in specific areas. Also upon suggestion by the social worker, the counselor-assistant could act as liaison between patient and nurse, patient representative or other appropriate staff member.

4. Group supervision was the program mechanism which allowed for "refueling" for the counselor-assistants; a vital part of performing their tasks. It provided a way of developing and growing via shared experience and general critiques of performance. It assured a supportive atmosphere in which to complain, or share joys or sorrows. Group supervision was a mechanism which had the flexibility to go from the reporting of all experiences of the counselor-assistants, to their discussing specifics and new ways of working, to learning together about special areas or facilities. It was an important mechanism both as an effective way to supervise their work and

as a factor in their continued high level of motivation.

Following the pilot phase of this project data was collected and analyzed to evaluate the difficulties and strengths in implementing the program. This has been done by trying to look critically each step of the way at the process involved in setting up the new program. The forces that aided or constrained the movement of the project through each phase have been discussed. From this, we were able to obtain some sense of the value of the program to the variety of the participants, as well as to derive some pattern of variable interaction to help in future planning.

The initial objectives of this project have been met. We shall look in the following pages at how the program itself has continued, at attempts being made to expand it, and at interest shown by other institutions in the possibility of replicating it, before discussing suggested modifications.

Continuation of the Program at White Plains Hospital

The program of senior counselor-assistants for older patients continues at White Plains Hospital. After the initial experimental phase, the program was turned over to new leadership, a new full-time worker. The new director was a mature woman who has had much experience in medical settings both in direct service and supervisory capacities. She quickly became acquainted with the nature of the program and was pleased with the philosophy of the service offered. She took over leadership of the group supervisory sessions and was able to continue the positive aspects of such meetings for the counselor-

assistants. Her ability to take over the group and the group's willingness to accept her demonstrate that the program was geared to the institution as well as to individuals. The new program director has taken up the suggestions that the counselor-assistants were ready for more educational input. She has continued discussions around specific topics and even suggested readings in a variety of areas.

The counselor-assistants who remained, have become more sophisticated in their approach to patients, and need less supervisory time with their individual social workers. Still, certain basic concepts have to be continually stressed and supervision by well-trained social workers will always be essential.

Five of the seven counselor-assistants have remained working in the program. They have all tried to participate regularly, but have suffered a variety of problems which curtailed work for a short time for each of them.

One counselor-assistant suffered a mild heart attack, but as soon as his doctors allowed resumption of normal activities, he was back in the program and has continued since. Another counselor-assistant had to have surgery for throat polyps and had to discontinue coming until she could use her voice again. Still another became ill with the flu and this, combined with the exceedingly harsh winter kept her home for about four weeks. These three counselor-assistants have remained very loyal to the program and still come regularly two times a week to work with patients.

The other two counselor-assistants have, in the last two months, had to curtail their time at the hospital. One comes only once a week because of transportation problems and the other often

comes only once a week because she has had to care for her own ailing step-mother. The social workers see them as still providing a service, but continuity for the patients is lost with only a once weekly visit. Because of the interest of these volunteers in continuing to work in the program, and the small, but meaningful service they thereby provide, they have been encouraged by the social workers to continue in the program. Thus, they adhere to the spirit, but surely not the letter of the program philosophy.

Institutional Support for the Program

Informal assessment of the support for the program, made by conversations with nursing staff, volunteer director and hospital administrator, lead to the conclusion that the program is still seen favorably. Extra service is provided for some patients, some help is given directly to nursing and certainly to social work. The director of volunteers notes that the counselor-assistants have consistently maintained a high level of motivation, interest and excitement. The administrator sees the service provided as of value to patients and as an innovative attempt by the hospital.

Hospital administration has expressed interest in expanding the program if outside funding becomes available. The Director of Social Service, who has seen this to be a very useful program, wishes to see it continue and expand. To this end, we have prepared a grant application which she is using in searching for further funding. A program to employ economically disadvantaged senior citizens within the Office of the Aging, has expressed great interest in this program and

some financial backing may come through this source. If not, the social service director plans to pursue alternative sources because she has become convinced through this pilot project, that using older adults to provide a linkage function for older patients is a valuable and needed service.

Outside Interest in Developing Similar Programs

Since this program has become a reality, interest by representatives of other institutions has been expressed. The head of the Yonkers Office of the Aging was interested in the idea of the service and has met with the social service director and the author to discuss how they might encourage area hospitals to implement something similar.

At a workshop on volunteer services for older adults where the author reported on the development of the program, interest in replicating it was shown. Such interest varied from that of one older workshop participant who wanted to join the existing program, to that of the regional representative of the President's Council on Voluntary Action who requested information to use as a prototype for developing such programs.

The Social Service Department at Lenox Hill Hospital in Manhattan has been given some funds to develop a program similar to the one described here. The experience gained in the counselor-assistant program has enabled the author to consult on their evolving proposal.

It would seem that Elaine Brody's philosophy is becoming more universally accepted. She suggested that, "It is a mark of a civilized

society that it accepts the role of equalizer in providing special support for vulnerable groups."[5] There are cries that this must be so, even in these times of limited resource. Certainly, the older population is more vulnerable to the crises of illness and hospitalization. "Persons over 65 usually are hospitalized three times as often and stay in hospitals twice as long as younger patients."[6] Older people are also more vulnerable to differential treatment in hospitals accorded to people on the basis of age.[7] There is evidence that the aged are more vulnerable and have received less interested health care. This project has been one attempt to promote some equalization of service to this group. The interest being shown in the program effected at White Plains Hospital points to the fact that it is not only "civilized" but also timely to be developing such a program.

Harnessing the maturity, capacity for growth, interest and time of older people to give service to a group of "semi-peers" has also been shown to be a useful and mutually satisfying venture. Interest shown by the hospital in continuing the program as well as that shown by agencies and persons outside the hospital in reproducing it give added credence to the original concept and practical implementation.

Suggestions for Program Modifications and Additions

It is true that project objectives have been met, that the program continues at White Plains Hospital and that outside groups have expressed interest in the entire concept. However, several areas suggest themselves for modification in a continued or second program

at White Plains Hospital. These modifications include: (1) provision of service earlier in the patient's hospital stay, (2) more publicity for program when a patient is admitted to the hospital, (3) follow-up of patients discharged from the hospital, (4) greater publicity to involve physicians, and (5) having paid rather than volunteer counselor-assistants.

Provision of service earlier in hospital stay

We see by looking over data on patients seen by the counselor-assistants that often a patient was in the hospital for many days before being seen by the social worker and assigned to the counselor-assistant. This follows the general hospital pattern identified by Berkman and Rehr who states that the majority of patients are referred to social service in the "recovery" phase of their illness.[8] Their studies showed that "90 percent of patient situations referred to social workers came from sources outside of social work," and "most cases were concerned with 'discharge oriented' social needs."[9] When social workers controlled their own casefinding, patients were seen earlier in their hospitalization and the types of situations needing interventions were different.[10] Experience at White Plains Hospital has shown a similar situation and consequent diminution of social work intervention with problems of the impact of hospitalization.

The connection of social service to patients late in the hospital stay, diminishes not only the types of areas in which such service can be helpful, but dilutes the chance for development of a relationship. The goals of providing companionship for the patients,

while generally met by the counselor-assistant, could have been enhanced if this companionship were to have begun closer to the patient's first hospital days.

It would be useful to run a program using counselor-assistants with the added dimension of earlier entry into a relationship with the patient. This would begin to test out the hypothesis that more visits started earlier in the hospitalization would have a greater impact on patients. They would have a chance to know their counselor-assistant better, to be able to depend more on the service offered.

More publicity about program when older patient is admitted to the hospital

If when a patient over 60 years is admitted to the hospital, he is told of the availability of visits by the counselor-assistant, he is made that much more ready to use the service. A few of the patients interviewed, actually suggested that they would have been happy to have known that a counselor-assistant was going to visit them. It would seem that if the hospital were committed to and sure of such a service, its use would be strengthened.

If the counselor-assistant program were to be publicized more, expectation could function to sensitize patients to its use. It would be of interest to test out this hypothesis by randomly selecting patients who at hospital admission would be carefully told of the availability of the new service, while other patients who would also receive the service, would not have been given the raised expectation

initially. Differential use and perception of the service might vary with a differential expectation.

Follow-up for patients discharged from the hospital

Although the original proposal for this program included follow-up work by the counselor-assistants, in practice this feature had to be dropped. Because of staffing problems, the social work department could not allow extra community involvement at that time. Thus, during the course of this program we have no way of knowing how such an added service would have worked out from the point of view of the patients.

It would be useful to make some attempt in the future to add this dimension, or in another program, build it into the service rendered. It could be expected that contact with former patients, once they are discharged from the hospital would increase the linkage service provided for that patient. Greater knowledge could be gained regarding the outcome of discharge plans made in the hospital. More help could be given in connecting the older former patient to needed resources in the community. A more intensive continuity of service could result from the inclusion in the future of such follow-up services.

Greater publicity to involve physicians

In the evaluation, physicians were found to have little awareness of the institution of the new program. As we have seen, the fact that the physicians were unaware of the program in operation did not

seem to impinge upon the positive findings of the social workers, patients and volunteers, themselves. Yet, attempts at making them more aware of the service, even to the point of suggesting it for a patient would increase the credibility and enhance the use the patient could make of the counselor-assistant visits.

One of the simple factors involved in increasing physician awareness is time. As the program continues and the doctors are told more often by the social workers that their patients are receiving the additional service of counselor-assistant visits, the fact that such a service is available will become clearer. An example of this occurred just shortly after the pilot phase ended. One of the physicians who had been aware of the efforts to start such a program, still, when questioned later felt he knew very little about it and had no patients in it. Yet, this physician, just a few weeks after being questioned, stopped me in the hall to refer a patient who was "old, concerned and lonely" to receive visits from our special volunteers. Such a referral was probably due to being sensitized by the questionnaire to think about the new service. This is not an uncommon response, in that once a person is forced to confront a particular issue via some research instrument, he is then made more aware of its existence.

It was not within the scope of this project to follow-up physician responses with further testing. It would be interesting to add this to the design, if this project were replicated to see if the second time testing would, in itself, lead to different results.

Also built into a future program might be other ways to increase awareness and interest in a new program affecting patients.

Stepped up informal communication between social workers and doctors could be effected. In addition, further formal mechanisms for communication could be arranged. Such means could include a memo sent to each physician, a report of how the program is progressing to be given to those present at the monthly staff meetings, or even reports to specific doctors on specific interactions of their patients with a counselor-assistant.

While physician awareness is not essential to the operation of this program, it is discussed, because of the underlying concept of linkage. If such a program is to provide greater linkage between patient and hospital environment, it would follow that the doctor as a part of this environment ought to be involved. The ways suggested to increase physician awareness are useful, but it must be realized that they would operate in an area where interdisciplinary communication is generally difficult. Attempts at increasing awareness of a new program would sensitize doctors also to the social service department and help to educate them regarding appropriate roles for social work as well. Thus, positive payoff could be expected, if in any future program, special attempts were made to involve physicians in a deeper fashion than was accomplished here.

Using paid rather than volunteer counselor-assistants

The program described here was able to be of use to the participants, and in this form could be used by other institutions. However, it would still seem optimal to be able to pay the older adults who give the service for the following reasons: (a) It would add an extra reward and motivation for the work done; (b) There could be a

more heterogeneous group of counselor-assistants who could be from all economic levels; (c) It would provide an opportunity for employment for a new career for people over 60 years of age.

Added reward. In our society, payment for services is usually an indication of the value of these services. While the volunteers who became counselor-assistants in this pilot project were motivated and satisfied without receiving payment, it is safe to assume that if a salary were paid it would not only not be refused, but surely welcomed. Rewards of helping others, learning and growing are hardly diminished by the extra one of some monetary return.

Heterogeneous group of counselor-assistants. Experience with recruitment of these volunteers led to certain conclusions about their involvement. Coming four hours on each of two days a week was as much as any of them could give. Because the people selected to be counselor-assistants had special attributes, we are drawing from a population of active and involved older adults. What makes them suitable candidates for this position also makes them participants in conflicting areas of family involvements, other groups, work or other volunteer commitments. To give this much time necessitates strong motivation and a heavy commitment.

Being part of such a heavy volunteer commitment seems also to involve being free of financial concerns. The latter was well-illustrated by the inability to recruit lower-income older adults to the program. It was also shown by the fact that one of the most enthusiastic counselor-assistants had to leave the program, to find work

when her unemployment benefits ran out and she was using her savings to live on.

It is felt that a more heterogeneous group of counselor-assistants could have been selected if some remuneration were involved. Giving service at the hospital on a regular basis does involve costs. At the lowest level, transportation and lunch ought to be provided for any volunteer, particularly older people on fixed incomes. Better even would be an hourly salary commensurate with still maintaining eligibility for social security. This would provide an additional motivation for working in such a program and thus encourage participation of groups not generally able to volunteer services.

Providing an employment opportunity in a new career. Much has been written on the alienation from the mainstream of our senior citizens. Providing meaningful use of their labor is important to redressing this grievance. Paying for these labors is an additional force reintegrating them into feelings of productivity. Robert Butler bemoans the human waste in retiring people too early.

> Each year as thousands of people are encouraged or forced to retire, their skills, knowledge or wisdom are lost and their opportunities to instruct, teach, consult or advise, listen and reflect as well as to work are cut off.[11]

It is becoming more fashionable to change careers mid-stream; to allow some flexible course of working commitment to ensue at middle life. Why not, as Assimov suggests, encourage further flexibility later into life?[12] We are beginning to give credence to the suggestion that development continues until death.[13] Perhaps soon we can provide structures to fit together with this notion. Providing opportunities for voluntary service for older people would fit into the

notion of combatting one of the problems of retirement. It would alleviate the "lack of satisfying and adequate occupation for the new leisure time that results."[14] This is certainly one option that should be available, together with the flexibility it implies. The program described, in fact, is a good example of the provision of such opportunity. Yet, it would seem appropriate, particularly in developing a service to provide a linkage function for older adult patients, that it be tried again. This time providing the option of employment in a new career.

"Those qualities which are especially associated with middle and later life-experience, accumulated skills, knowledge, judgment, wisdom and perspective are discarded just when they are coming to fruition in human beings."[18] It has been the intent of the program produced within the context of this project to recover these qualities and put them to important use. Establishing avenues for pursuing a second or even third or fourth careers in later life, utilizing qualities germane to this period is a necessary endeavor. A program using paid counselor-assistants for older patients in an acute care hospital would be one small step in that direction.

Other Possible Uses of Counselor-Assistants

The concept of the "trained semi-primary group member," as defined earlier, to provide a linkage function has been shown to be a useful one. The general reaction of patients showing increased comfort in the hospital, and statements made regarding the more humane and interested care, lead us to believe that patient and institution were

being helped to touch. The service provided was seen as helpful to patients, to the social work staff and to the older volunteers as well. Such a service could be developed in other acute care hospitals, and would provide to these this extra service dimension for older patients.

In teaching hospitals, such a program could aid in a reciprocal learning process. The counselor-assistants could partake in some of the learning with house staff and could contribute their impressions and insights via a differing perspective to the staff.

We have been looking at this specific type of volunteer or worker in the context of an acute medical hospital. It would seem that a program such as the one described here, with slight modifications could be used as a prototype for providing a linkage function for older people within all types of institutions. The "trained semi-primary group member" could provide linkages for residents of nursing homes both to the facility and to the community. They could do the same for patients in rehabilitation or convalescent care hospitals. Even facilities for the terminally ill could make use of such services. Such a program could be instituted in each such facility and would provide a needed new service dimension as well as an appropriate area of employment for older workers.

Other ways to involve other facilities in using such a service could be developed. While specific institutions should provide their own orientation and socialization process for such counselor-assistants, a centralized organization could take over the major tasks of recruiting, selecting, training and even partially supervising a cadre of such workers who could be available to become based in a variety of facilities. A governmental group like the County Office of the Aging could

develop such a process and fund workers to provide service in facilities within the area. Even a private organization like the Senior Personnel Employment Committee could perhaps become interested in developing such a cadre of workers who could be employed in a variety of facilities. The skills of such workers could be developed to provide linkages in the form of companionship, liaison, and continuity, as well as becoming advocates over time.

There are far-reaching possibilities for developing programs based on the conceptualization and experience as reported here. It would be useful to try modifications of the program, as suggested and to test out some of the hypotheses which grow out of the experience reported here.

Footnotes

[1]Marcella Farrar and Mary L. Hemmy, "Use of Non-professional Staff in Work with the Aged," Social Work, VIII (July, 1963), 44-50.

[2]*Ibid.*, 45. [3]*Ibid.*, 46. [4]*Ibid.*, 47.

[5]Elaine Brody, "Serving the Aged: Educational Needs as Viewed by Practice," *Social Work*, XV (October, 1970), 44.

[6]*Ibid.*, 48.

[7]David Sudnow, "Dead on Arrival," *Transaction*, 5 (November, 1967).

[8]Barbara G. Berkman, and Helen Rehr, "The Sick Role Cycle and the Timing of Social Work Intervention," *Social Service Review*, 46: 4 (December, 1972), 577.

[9]Helen Rehr and Barbara Berkman, "Effects of Differential Timing of Social Service Intervention with Aging Patients," (New York: Mt. Sinai Hospital, June, 1968 - May, 1969).

[10]Barbara G. Berkman and Helen Rehr, "Early Social Service Case Finding for Hospitalized Patients," *Social Service Review*, 47: 2 (June, 1973), 256-265.

[11]Robert N. Butler, *Why Survive? Being Old in America* (New York: Harper and Row, Inc., 1972), p. 65.

[12]Issac Assimov, "The Coming of Age of Age," *Prism* (January 1975), 53-56.

[13]Fred Berl, "Growing Up to Old Age," *Social Work*, VIII (January, 1963), 85-91.

[14]Gladys Worthington, "Older Persons as Community Service Volunteers," *Social Work*, VIII: 4 (October, 1963), 71.

[15]Butler, *Why Survive?*, p. 64.

EPILOGUE

> In truth, it is easier to manage the problem of death than the problem of living as an old person. Death is a dramatic, one-time crisis, while old age is a day to day and year by year confrontation with powerful external and internal forces; a bittersweet coming to terms with one's own personality and one's life.[1]

It was in the spirit of high regard for the "bittersweet coming to terms with life" that the project reported here was conceived. Its growth was nurtured by concerns for enhancing, albeit in a small way, the image and esteem of older people. Both the providers and receivers of a service designed to combat an existing imbalance are older adults. While the group dealt with is heterogeneous certainly, several common bonds exist. A generational locus, particular life stage and development in a common era are very major factors in the lives of all the program participants. As in most service arenas, both the "givers" and "receivers" of the service actually "received" a great deal.

The guiding value was producing extra service for a population group seen as having received less. Combined with that value was one of the need to contribute to continued development and feelings of usefulness for the older adult. These values, together with application of the theory of institutional typology and nature of tasks led to the formulation and execution of the program described in these pages.

It is with a sense of excitement that the program begun in this project continues. It is in the spirit of hope that suggestions for further work in this area are made. "We have promises to keep and miles to go before we sleep."[2]

Footnotes

[1]Robert N. Butler, Why Survive? Being Old in America (New York: Harper and Row Publishers, 1975), p. 1.

[2]Robert Frost, "Stopping by the Woods on a Snowy Evening."

APPENDICES

APPENDIX A

MINI-PROPOSAL FOR FUNDS

COUNSELOR ASSISTANTS FOR A GERIATRIC PROGRAM IN A COMMUNITY HOSPITAL

The rationale behind this project is two-fold. One, to provide service in an area of unmet need in geriatrics; two, to utilize a specific manpower resource, which because of its special qualities may be able to best answer this need.

UNMET NEEDS

It has been documented that many older people find themselves needing more medical care than they did at earlier stages of their lives. Although the medical needs may be met, for a variety of reasons there is often neither time nor resource to help meet the concommitant social and psychological concerns of these patients. The important linkages between patient and hospital, patient and family and patient and community resources frequently break down when the older adult is hospitalized for a physical ailment. A major need for such patients would be to provide a service which would reestablish the balance between the patient, his family and institutions with which he is involved.

Such older patients may need someone to encourage and enable good communication with medical personnel. They may need help in identifying the existence of special resources and occasionally require assistance in utilizing these. Many may need someone to listen, understand and empathize when other needs have been met.

SPECIAL MANPOWER RESOURCE

There is a large resource of capable adults who because of retirement are no longer in the labor force. They are physically fit and mentally alert. Many of these senior members are eager to become involved in giving service to others. They could be so employed.

Such an age cohort would be more or less contemporary to the older hospital patient and because of this bring specific attributes which could be utilized in helping the older patient. This older worker would have shared similar life experiences and can more readily empathize and identify with the older patient. The older worker with his similar intergenerational life space could be helpful in interpreting the older patients needs to family and community resources. He could be particularly alert to discovering generalized needs of the older hospitalized person as well. The older person who could be utilized to give service in the hospital would have blocks of time to be distributed as needed.

Members of this specific manpower resource would only be asked to help with the concerns of the older patient after a period of training. They would be helped to use the resources they already bring from their maturity and life experiences in order to help others. With their special attributes and such training they could be employed in the hospital and provide linkage of its services to the needs of older patients.

COMMUNITY HOSPITAL

A community hospital is frequently the mainstay of medical care in a local area. Patients there are seen by a variety of private physicians. A large proportion of hospital patients are older adults, but sufficient services to meet the specialized

needs of such patients do not exist.

Recognizing this, the President of the Board of Governors, and the Executive Director of White Plains Hospital have strongly endorsed this project and have encouraged the Director of the Social Service Department, who has indicated great interest in the project, to proceed with joint planning with the Mental Health Association of Westchester. If the results of this project prove successful at this hospital, the program could become a prototype for such facilities throughout the country.

CONCEPT OF THE PROGRAM

Goals:

Primary: The primary goal of the proposed program is to introduce the special manpower resource, as described, into the hospital system to become counselor assistants giving special service to the older patients.

Subgoals: These subgoals involved in providing this service would include:

1. Provide link between patient and hospital
2. Provide link between patient and family
3. Provide link between patient and community resources
4. Provide increased service contacts with older patients
5. Provide source of information on resources for the aged within the hospital setting and information and referral for community services for the discharged patient
6. Provide , through relationship and service, relief of isolation, confusion and anxieties of the older patient
7. Provide continuity of contact with patients following discharge from the hospital

Roles of the Counselor Assistants:

The counselor assistants would provide service to meet the stated

goals by performing specific roles:

1. To provide empathic, warm relationship to older patients in the hospital
2. To give knowledge about and help in linking up to community and financial resources for senior citizens
3. To help patients in planning for their discharge from the hospital
4. To help family perform appropriate roles for the patient
5. If no family, find community resources to help perform some family functions
6. To have some firsthand knowledge regarding community resources, nursing homes, etc. and to act as advocate if these are not meeting the needs of the patients
7. To gather data on perceived needs of older patients

<u>Selection Process</u>:

<u>Recruitment</u> of applicants to work in the program would be through physicians, hospital staff, senior citizen groups and agencies serving the elderly.

<u>Selection</u>: Primary responsibility for selection rests with the Director of the Social Service Department of White Plains Hospital, with assistance from the project director and a Mental Health Association staff representative.

<u>Criteria for Selection</u>: In selecting people for the program, the qualities to be looked for are warmth, ability to relate easily to others, flexibility and interest in fulfilling the roles of the counselor assistant.

<u>Completion of Selection</u>: Once 6 - 8 people who are over 60 years, bright, warm, capable and interested are selected, the training phase of the program could begin.

Training Program:

To prepare the counselor assistants for their responsibilities in dealing with the older hospital patient, a training program is planned:

Modalities Used in Training:

1. Lecture and seminars
2. Role-playing
3. Discussions
4. Case Vignettes - suggestions for handling
5. Supervised field-work in hospital

Areas to be Covered:

1. Interviewing techniques
2. Orientation to commonly encountered medical and psychiatric syndromes
3. Community resources
4. Dealing with the hospital and physicians
5. Working with outside agencies
6. Working with families
7. Self-awareness
8. Use of group meetings and supervision
9. Record keeping and use of forms
10. How to keep balance between institution and family
11. Collection of data on patient needs

Staff Involvements:

Medical, nursing, social work and related staff will be involved in the training and preparation of a reference manual for use by the counselor assistants.

Personnel Needs:

In order to implement the proposed program, specific personnel would be needed:

1. Program Director
2. Half- time secretary
3. Consultants
    a) Director of social service department - White Plains Hospital
    b) Director of Mental Health Association
    c) Research Consultant
4. Guest Speakers
5. 6 - 8 counselor assistants (alert, interested older adults who would be selected to receive a salary while being trained and then employed in the program)

RESEARCH AND EVALUATION

From the beginning, formal research and evaluation components will be included for assessing the effectiveness of the project.

1. Systemmatic description of actual program operation
    a) Demographic data on patients and counselor assistants
    b) Records of contacts - type , number, with whom, etc.
2. Objective assessment of goal attainment
    a) Set up two groups of older patients in the hospital One group will receive the service of the counselor assistants; the patients in the other group will not.
    b) For patients in both groups, administer questionnaires relating to their attitudes toward total care in the hospital and discharge experiences.
        1) Assess from these if patients felt that the program helped or hindered their care and in what way.

c) Collect data regarding actual services performed for specific patients

1) Administer questionnaires to hospital staff, physicians, family members to assess their views of the effectiveness of the services rendered.

d) At start of the program and at its end, administer questionnaires to selected hospital staff and physicians to get at attitudes toward program itself and to measure any change.

3. Collection of data on needs of the older patient that are discovered by the counselor assistants

4. Possible unintended outcomes, i.e. shorter hospital stay, fewer contacts with social service department, lower readmission rate to the hospital and lower utilization of the hospital emergency room

a) May gain access to some of this information by measuring changes in these areas and comparing figures of control group against group receiving new service

b) It is hope that the analysis of such data may generate future hypotheses concerning service delivery to older patients in the medical hospital

The sum of about $40,000 would be sufficient to meet the budget requirements of this proposal for a one year duration of the demonstration.

Projected Budget:

Project Director (Half time)	$10,000
Secretary (Half - time)	3,5000
Counselor Assistants 8 @ $3.00/hr. x 12 hrs./wk.	14,4000
Consultants:	
Director of Mental Health Assn.	3,000
Director, Soc. Service Dept. White Plains Hospital	4,000
Research Consultant	2,500
Telephone	1,000
Travel	1,000
	$39,4000

APPENDIX B

STATEMENT SENT TO ORGANIZATIONS TO HELP RECRUIT VOLUNTEERS

DESCRIPTION OF PROGRAM

White Plains Hospital is embarking upon a Pilot Project to augment social services to senior citizens who are patients here.

We need senior volunteers to act as counselor-assistants in the social service department. The volunteers selected for the program will work on a one-to-one basis with older patients. They will help in giving companionship, psychological support in the face of illness and information about appropriate community resources. The volunteer must be tactful, resourceful and sensitive to others' feelings, and able to maintain confidentiality.

All volunteers will participate in a six week training program of four hours per day twice a week, during which they will learn about the hospital and patient care, as well as community resources. The volunteer will be helped to begin working directly with patients during this training period. Following this, the volunteer will be asked to give two four-hour sessions per week on the job for a period of at least three months. Ongoing staff supervision, including weekly group discussion meetings will be provided.

Anyone who is interested in applying to volunteer in this project or who would like further information in this regard, please call:

949-4500, Ext. 2079

and ask to speak to: (Mrs.) Susan Blumenfield
Program Coordinator

or

(Mrs.) Carol Rocklin
Director of Social Services

APPENDIX C

QUESTIONNAIRE GIVEN TO VOLUNTEERS BEFORE STARTING TRAINING PROGRAM

INTERVIEW SCHEDULE for VOLUNTEERS in the PROGRAM

1. Name ______________________
2. Address ______________________
3. Phone No. ____________
4. Date of Birth ____________
5. Religion ____________
6. Marital Status ____________
7. Children 1. 2. 3. 4.
   Age:
   Sex:
   Location:
8. Last year of Formal Education ____________
9. Previous Work Experience ______________________

   ____
10. Have you ever volunteered before? ____
    What did you do, and when? ______________________

    ____
11. Have you had experience with illness and hospitals?
    Yourself:
    With a relative:
    Describe these ______________________
12. Where did you hear about this program? ______________________
13. What made you interested in becoming part of the program?

    ____

    ____
14. What do you hope to give to program? ______________________

    ____
15. What do you hope to get from being part of the program? ____________

    ____

APPENDIX D

RESOURCE MANUAL

COUNSELING

1. FAMILY SERVICE AGENCIES

Catholic Charities Family & Community Services — 949-9500
25 Hale Ave., White Plains, N. Y.
Provides casework service, advocacy and counseling for the aged and their families.

Family Consultation Service of Eastchester — 961-4773
551 White Plains Rd., Eastchester, N. Y.
Provides casework services to individuals and family; also some homemaker services available.

Family Service of Westchester, Inc. — 948-8004
470 Mamaroneck Ave., White Plains, N. Y.
Irwin M. Stein, Executive Director
This is a social work agency specifically designed to help families with family problems as well as individual elderly persons. Services include a Widows & Widowers social group and "Outreach to newly bereaved", services for elderly and counseling.

SAGE (Senior Advice Guidance Education) — 698-6550
1 Depot Plaza, Mamaroneck, N. Y.
This is a program under auspices of Family Service of Westchester and is funded through CMHB, United Way and private foundations. It is a hotline for information service and referral, associated with back-up services by Family Service of Westchester.

Westchester Jewish Community Services, Inc. — 949-6761
172 South Broadway, White Plains, N. Y.
Lenore Luftman, Consultant to the Elderly
Agency offering geriatric counseling both to the older person and his family; professionaly supervised homemaker service, guidance to the elderly and to adult children on supportive community placement.

2. COUNTY SPONSORED COUNSELING SERVICES

Westchester Community Mental Health Board — 423-9892
Mobile Geriatric Service
45 South Broadway, Yonkers, N. Y.
Counseling for county's aged and their families. Team is able to see person in his home.

Westchester County Department of Social Services — 682-2467
Division of Services 424 County Office Building
White Plains, N. Y.
Social work and counseling services to older people and their families is offered via specialized service units.

COUNSELING (cont'd)

Westchester County Office for the Aging — 682-2404
County Office Bldg., White Plains, N.Y.
Joseph Fortelli, Director
Offers information, referral and consultation to aging, their families, and social and other agencies on problems including housing and home health care. Advises and stimulates public and private organizations and programs to develop new and extend existing services. Sponsors conferences on problems and services for elderly. Counsels County Executive on policies for aging.

3. INDEPENDENTLY SPONSORED AGENCIES

Mental Health Association of Westchester, Inc. — 949-6741
29 Sterling Ave., White Plains, N. Y.
Esther Mallach, Executive Director
Counseling for individuals and families with personal problems. Suicide prevention and crisis intervention. Resources for relatives, professionals and concerned citizens. Provides educational materials and advocacy programs in area of aging.

4. INSTITUTIONAL SERVICES

Burke Rehabilitation Center — 948-0050
785 Mamaroneck Ave., White Plains, N. Y.
Counseling is available in connection with other services.

New York Hospital - Cornell Medical Center — 949-8300
Westchester Division 21 Bloomingdale Rd. W.P.,NY
Through both outpatient and inpatient services, psychiatric and psychological counseling is offered to aged patients and their families. A geriatric social worker available to all aged patients.

St. Agnes Hospital — 949-4000
North Street, White Plains, N. Y.
Outpatient and inpatient counseling services are available by contacting Social Service department.

White Plains Hospital Association — 949-4500
Davis Ave., White Plains, N. Y.
Social Service department, X. 2079
Outpatient and inpatient counseling services available.

5. WESTCHESTER COUNTY MENTAL HEALTH BOARD - MOBILE GERIATRIC SERVICE

45 South Broadway, Yonkers, N. Y. — 423-9892
Provides family counseling, consultation with other professionals and psychiatric evaluation for elderly in the community. Also screens geriatric admissions to state hospitals.

EDUCATIONAL OPPORTUNITIES

College of White Plains — 949-9494
North Broadway
White Plains, N. Y.
No special offerings for seniors, but all are eligible to take courses in continuing education Program and invited to attend any of college-sponsored community events.

Elizabeth Seton College — 969-4000
North Broadway & Odell Ave.
Yonkers, N. Y. Ms. Ann Healy - Director of Sr. Program
The college sponsors a program specifically for senior citizens. They provide an exercise class, lunch and lectures on Tuesday and seniors are invited to enroll in other courses as well.

Westchester County Cooperative Extension — 428-4870
Home Economics Division
904 County Office Building
White Plains, N. Y.
Information for consumers to use in order to make wise buying decisions is available through conferences or in U.S.D.A. & Cornell University Extention publications. May schedule talks on nutrition, food buying and family business management directed to needs and interest of senior Americans.

Westchester County Department of Recreation and Parks — 682-2415
County Office Building
White Plains, N. Y.
Various educational programs are offered specifically to senior citizens in such places as housing developments for the elderly.

Westchester Library System — 761-7620
285 Central Ave.
White Plains, N. Y.
Adult Services Consultant
Large print books, lectures and film programs held in local public libraries, delivery service to shut-ins, talking book services for blind and handicapped, deposit book collections in senior citizen centers and retirement homes on request. Informational material available on subjects of interest to seniors.

White Plains Adult Education Center — 948-3440
Rochambeau School
228 Fisher Ave., White Plains, N. Y.
Day and evening classes conducted in over 100 areas from art to yoga. Classes held in senior citizens center, library, High school, in addition to Rochambeau. Most classes free to senior citizens.

Other adult education classes available throughout Westchester in local high schools.

EMPLOYMENT

New York State Employment — 946-7850
174 Grand St.
White Plains, N. Y.

Jobs listed for people of all ages. Interviews and employment referrals.

Senior Personnel Employment Committee — 761-2150
158 Westchester Ave.
White Plains, N. Y.

Personal interviews 9 a.m. to 12 noon Monday through Friday, September to June. Men and women over 60 may contact this non-profit agency for full-time and part-time positions. Jobs range from bookkeepers, companions, carpenters, gardeners, plumbers, secretaries, sales people, etc. No fee is charged.

EXTENDED CARE FACILITIES

Bethel Methodist Home
19 Narragansett Ave.
Ossining, N. Y.
941-7300

Brandywine Nursing Home
620 Sleepy Hollow Road
Briarcliff Manor, N. Y.
941-5100

Cabrini Nursing Home
115 Broadway
Dobbs Ferry, N. Y.
693-6800

Cedar Manor Nursing Home
Cedar Lane & Stormy Town Rd.
Ossining, N. Y.
761-1600

Centre Manor Nursing Home
319 Centre Ave.
New Rochelle, N. Y.
636-8683

Cortland Nursing Home
110 Oregon Rd.
Peekskill, N. Y.
PE 7-4751

Dumont Nursing Home
676 Pelham Rd.
New Rochelle, N. Y.
632-9600

Greenwich Laurelton
1188 King St.
Greenwich, Conn.
203-531-8300

Howe Ave. Nursing Home
16 Guion Place
New Rochelle, N. Y.

Hudson View Nursing Home
65 Ashburton Ave.
Yonkers, N. Y.
YO 3-4000

EXTENDED CARE FACILITIES (cont'd)

King St. Nursing Home
787 King St.
Port Chester, N. Y.
937-5800

Miramichi Nursing Home
6 New York Ave.
White Plains, N. Y.
949-8525

New Rochelle Nursing Home
31 Lockwood Ave.
New Rochelle, N. Y.
576-0600

Nurs. Home and E.C.F. of White Plains
37 DeKalb Ave.
White Plains, N. Y.
946-1440

Osborn Nursing Home
89 N. Broadway
White Plains, N. Y.
949-4683

Port Chester Nursing Home
1000 High St.
Port Chester, N. Y.
937-1200

Putnam Weaver
Weaver St.
Greenwich, Conn.
203-869-3553

St. Joseph's N. H.
127 S. Broadway
Yonkers, N. Y.
965-6400

Sans Souci Nursing Home
304 Palisades Ave.
Yonkers, N. Y.
GR 6-0120

Sarah Neuman
845 Palmer Ave.
Mamaroneck, N. Y.
698-6005

EXTENDED CARE FACILITIES (cont'd)

Shalom Nursing
10 Claremont Ave.
Mt. Vernon, N. Y.
699-1600

Sky View Haven Nursing Home
Route 9
Croton-on-Hudson, N. Y.
271-5151

Somers Manor
Route 100
Somers, N. Y.
CE 2-5101

Sprain Brook
77 Jackson Ave.
Scarsdale, N. Y.
472-3200

Tarrytown Hall Nursing Home
Wood Court
Tarrytown, N. Y.
631-2600

United Home for Aged Hebrews
60 Willow Drive
New Rochelle, N. Y.
NE 2-2804

Westledge
East Main St.
Peekskill, N. Y.
PE 7-8400

Woodland Nursing Home
490 Pelham Rd.
New Rochelle, N. Y.
NE 6-2800

Morningside House
1000 Pelham Parkway
Bronx, N. Y.
212-863-5800

Wellington Hall Nursing Home
301 Union St.
Hackensack, N. J.
201-487-4900

FINANCIAL

Catholic Charities Family and Community Services — 949-9500
25 Hale Ave.
White Plains, N. Y.
Emergency assistance is given on a temporary basis, based upon individual need.

Social Security Administration — 682-1540
200 Mamaroneck Ave.
White Plains, N. Y.
Completes applications and answers questions regarding benefits and eligibility requirements for social security, medicare and supplemental security. Income program.

Westchester County Department of Social Services — 682-2467
Division of Services
424 County Office Building
White Plains, N. Y.
Social work and counseling services to older people and their families is offered via specialized service unit.
Medicaid - 428-9200
Institutional Assistance Unit - 682-3225

White Plains Senior Citizens Center — 949-4850
25 South Broadway
White Plains, N. Y.
Mrs. Marion Marazio, City Services Officer
This agency gives information on a variety of matters, including financial aid. Small amounts of money and baskets of food are given to needy at Christman. Aged people who have been referred may be assisted with donations of household and personal necessities. Information and assistance is given upon request concerning the Food Stamp program and Medicaid.

HOME SERVICES

FRIENDLY VISITING

There are many programs of friendly visiting in the area. Some programs serve the indigenous groups to which the elderly belong- Churches, small social organizations, family service agencies and the like. Church and synagogue members have auxiliary services for visiting sick and/or disabled members. These are not directed to elderly per se and serve only actual members. Social organizations like the Old Guard, Elks, Lions, Rotarians and Kiwanis serve their homebound members in similar fashion.

1. American Red Cross — 946-6500
   106 N. Broadway, White Plains, N. Y.
   When requested, this organization will send volunteers to shut-ins on a friendly visiting basis. Also, a check-in telephone service is sponsored, with volunteers calling older persons to check on their safety.

2. Westchester Lighthouse, N.Y. Association for the Blind — 761-3221
   346 Mamaroneck Ave., White Plains, N. Y.
   Adult services include case work service, home-teaching in self-care, Braille, typing, handcrafts, homemaking, mobility instruction, weekly recreation meetings in various communities, distribution of Talking Book machines and records, referrals for vocational rehabilitation and lighthouse training, camping, low vision, lens service, volunteer visiting.

FAMILY AGENCY - HOMEMAKER SERVICES

1. Catholic Charities Family & Community Services — 949-9500
   25 Hale Ave., White Plains, N. Y.
   Homemaker services on a temporary basis are provided upon request. Sliding scale fee.

2. Family Service of Westchester, Inc. — 948-8004
   470 Westchester Ave., White Plains, N. Y.
   Mrs. Betty Stith
   Provides services to the aged, including homemaker service and volunteer service.

3. Westchester County Department of Social Services
   Division of Family & Child Social Services
   Homemaker Unit

   Homemaker services provided for adults who are financially self-sufficient but unable to pay in full for a homemaker's service. This unit often funds homemakers provided by other agencies.

4. Westchester Jewish Community Services, Inc. - Panel Homemakers 949-6761
172 South Broadway, White Plains, N. Y.
Mrs. Elizabeth Melamid, Supervisor-Homemaker Services
Provides long-term homemaker assistance to the elderly on a part-time or full-day basis. Funding must be secured either from family or from Westchester County Department of Social Services, Homemaker Unit. Limited short-term coverage can be provided on sliding scale fee.

PRIVATE HOMEMAKER - HOME HEALTH AIDE SERVICES

1. Affiliated Home Care Homemaking Service, Ltd. 725-0873
658 Central Ave.
Scarsdale, N. Y. 10583

2. Homemakers Upjohn 428-8525
470 Mamaroneck Ave.
Suite 410
White Plains, N. Y. 10605

3. Professional Care, Inc. 428-2522
76 Mamaroneck Ave.
White Plains, N. Y.

4. Quality Care, Inc. 428-1911
99 Mamaroneck Ave.
White Plains, N. Y. 10601

5. Senior Personnel Employment Committee 761-2150
158 Westchester Ave.
White Plains, N. Y. 10601

6. Unlimited Care, Inc. 428-8940
180 Post Rd.
White Plains, N. Y. 10601

TELEPHONE OUTREACH SERVICES

1. Office of the Aging - Telephone Outreach Service 682-2404
Service offered by County Office in which a trained volunteer calls senior citizens who have signed up on a regular basis at a mutually convenient time. If caller determines that assistance is needed, he proceeds with necessary arrangements.

2. Red Cross - Telephone Outreach 946-6500
Gives service similar to one offered by office of aging.

3. White Plains Senior Citizen Center 946-7722
Just beginning a telephone outreach program similar to those above. Members will call seniors in the community who request the service.

Affiliated Home Care Homemaking Service, Ltd.

658 CENTRAL AVENUE • SCARSDALE, NEW YORK 10583 • (914) 725-0873

AFFILIATED HOME CARE:
PROVIDES THE FOLLOWING SERVICES IN THE HOME

<u>Electrocardiograms</u>

*Institutions (not mounted or interpreted. $10.00

Patients Homes
(a) mounted and interpreted. $30.00
(b) not mounted and interpreted. $15.00

<u>Home Phlebotomy Service</u>

$7.00 for all calls located within a 10 mile radius of White Plains.

The above price include venipuncture, tubes, needles, band aids, specimen bags and transportation fees. Technicians collect specimen, fees and insurance forms and return them to the lab.

Also available upon request: Oxygen, Supplies and Equipment, and the most complete line of health care products and convalescent aids.

<u>Nurses Aids - Home Attendent</u>

Minimum of 5 hours three days a week . . . . $4.00 per hour

Less than 5 hours three days a week. . . . . $4.25 per hour

24 hour coverage . . . . $42.00 per day

<u>Registered Nurses</u>

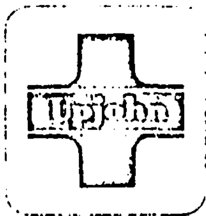
Minimum of 8 hours . . . . $7.00 per hour

<u>Licensed Practical Nurses</u>

Minimum of 8 hours . . . . $6.00 per hour

*Hospital, Nursing Homes and Extended Care Facility

Surgical & Medical Equipment



HOMEMAKERS
UPJOHN
470 Mamaroneck Avenue, Suite 410
White Plains, New York 10605
Ph. (914) 428-8525

Oct. 28, 1975

HOMEMAKER SERVICE

	Hourly Rate	Eight Hours	24 hour Rate
Professional Nurse (RN)	$6.95	$55.60	
Licensed Nurse (LPN)	5.95	47.20	
Home Health Aide Nurses' Aide			
1. Patient Care & Light Housekeepking	4.00	32.00	$45.00
2. More than one patient	4.80	38.40	
Home Care (Homemaker)			
1. Child Care & Full Home Management (Substitute Mother)	4.80	32.00	45.00
2. Companion	4.00	32.00	45.00

* All employees are bonded and insured and supervised by a Registered Nurse and a Social Worker.

(516) 433-1105

QUALITY CARE INC.

Nursing Division of Health Delivery Systems, Inc. • 57 North Broadway • Hicksville, L.I., New York 11801

David A. Scheinman, M.D
Medical Consultant

Gerald A. Smith, R.N., P.H.N.
Director

Herman M. Schuster
President

SERVICE CHARGES MARCH 1, 1973

Home Health Aides/Nurses Aides	$ 3.60 - 3.75 per hour 38.00 - 40.00 per day(live-in)
Home Managers/Homemakers	3.50 - 3.60 per hour 38.00 per day (live-in)
Companion/Hospital Sitter	3.50 per hour 36.00 per day (live-in)
Licensed Practical Nurse	6.00 - 6.40 per hour
Registered Nurse	7.00 - 7.50 per hour

Above charges vary within the range depending upon the patient's needs and family requirements.

Because of our concern for the QUALITY of care we provide you, our client, ALL Quality Care, Inc. employees are professionally screened, insured, bonded and supervised by an R.N., P.H.N.

QUALITY CARE INC.

SERVING ALL OF NEW YORK CITY AND LONG ISLAND

24 HOURS A DAY - 7 DAYS A WEEK

NASSAU/SUFFOLK (516) 433-1105

BROOKLYN/QUEENS/STATEN ISLAND (212) 633-0608

MANHATTAN/BRONX (212) 679-0840

Westchester
99 Mamaroneck Ave.
White Plains, N.Y. 10601
(914) 423 1911

PROFESSIONAL CARE INC.
207 EAST 45th STREET • NEW YORK, NEW YORK, 10017 • [212] 986-1144

MARTIN WEISSMAN
President

ISRAEL COHEN
Vice President

DIANE SCHUELLER
Director of Care Placement Services

GERARD LEVI M.D.
Medical Consultant

428-2522
Irene Jackson 76 Westchester Ave.

RATE SHEET

~~NURSING HOMES~~

NURSES AIDES	$4.00 per hour
HOMEMAKERS	3.90 per hour
COMPANIONS	3.90 per hour
LIVE INS	41.00 per day
DOMESTICS	3.80 per hour
ORDERLEYS	4.25 per hour
LPN'S	6.50 per hour
RN'S	7.50 per hour

ALL EMPLOYEES BONDED AND INSURED.

MEDICAL AND SURGICAL SUPPLIES AND AMBULANCE AND AMBULETTE SERVICE ALSO PROVIDED.

Medicaid Approved.

180 EAST POST RD. / WHITE PLAINS, N.Y 10601 / (914) 428 8940

HOWARD H. SHERMAN, M.D.
Consultant
MARIA BROWN, R.N.
Consultant

SERVICE CHARGES - 1975

Home Health Aides/ Nurses Aides	$ 3.75 per hour 40.00 per day (live in)
Home Supervisors/ Homemakers	3.75 per hour 40.00 per day (live in)
Licenced Practical Nurse	6.00 per hour
Registered Nurse	7.00 per hour

AROUND THE CLOCK SERVICE

7 DAYS A WEEK

Serving the nursing needs of the community

THE PAID NEIGHBOR SERVICE

SENIOR PERSONNEL EMPLOYMENT COUNCIL

WHITE PLAINS - 158 Westchester Avenue - 761-2150

AFFILIATE OFFICES:

BRONXVILLE-EASTCHESTER-TUCKAHOE	-	779-2833
FAIRVIEW-GREENBURGH	-	682-5258
MOUNT KISCO	-	666-7862
NEW ROCHELLE	-	235-7725
YONKERS	-	968-9320

DO YOU NEED A PAID NEIGHBOR?

The PAID NEIGHBOR is a program established primarily to help the elderly suffering from the normal infirmities of old age. It provides simple household services with the cheerful companionship necessary to maintain the elderly in familiar home surroundings.

The PAID NEIGHBOR is a retired person of varied background, male or female: the retired housekeeper; the housewife who cared for her own family for many years and is no longer needed; the clerical worker, whose commercial skills are outmoded; the sales person no longer able to take the rigors of this field, etc.

The PAID NEIGHBOR is able to perform light housekeeping tasks, such as marketing, assisting with baths when necessary, preparing nutritious meals and keeping the person and his surroundings clean and comfortable while providing cheerful companionship throughout the time involved.

PAID NEIGHBOR positions are temporary, varying from a week to several months duration. They range from 3 to 5 days a week, and those so employed work a minimum of 4 hours daily. Whenever possible, the PAID NEIGHBOR is placed in an easily accessible location.

The PAID NEIGHBOR receives a minimum of $3.00 an hour plus transportation costs.

The PAID NEIGHBOR SERVICE is designed to fill a great unmet need in the area of home care. In addition it provides job opportunities for the able Senior Citizen wishing to continue his life as an independent and useful person, thus proving that ABILITY IS AGELESS.

An Agency of The United Way of Westchester and The Greater Scarsdale United Fund and Council, presently completing 20 years of service to the community.

1/75

HOSPITALS

General Hospitals in the Area

1. Lawrence Hospital
   55 Palmer Ave.
   Bronxville, N. Y.
   337-7300

2. Mt. Vernon Hospital
   N. 7th Ave.
   Mt. Vernon, N. Y.
   664-8000

3. New Rochelle Hospital Medical Center
   16 Guion Place
   New Rochelle, N. Y.
   NE 2-5000

4. Northern Westchester Hospital
   E. Main St.
   Mt. Kisco, N. Y.
   666-6777

5. Phelps Memorial Hospital Association
   North Broadway
   No. Tarrytown, N. Y.
   631-5100

6. St. Agnes Hospital
   North St.
   White Plains, N. Y.
   949-4000

7. St. John's Riverside Hospital (Andrus Pavillion)
   967 N. Broadway
   Yonkers, N. Y.
   YO 3-3535

8. St. Joseph's Hospital
   127 S. Broadway
   Yonkers, N. Y.
   965-6700

9. United Hospital
   406 Boston Post Rd.
   Port Chester, N. Y.
   WE 9-7100

10. Westchester County Medical Center
    Valhalla, N. Y.
    592-8500

11. Yonkers General Hospital
    127 Ashburton Ave.
    Yonkers, N. Y.
    YO 5-8200

whether patient is accepted within a week. If eligible, come when bed available.

5. Kingsbridge Veterans Administration Hospital
Kingsbridge Rd.
Bronx, N. Y.
212-584-9000 X. 248 Admitting
Any veteran is eligible for rehabilitation help in this facility without charge. Patient has to be able to go to the bathroom alone before coming here.
When VA Hospital receives application they call if patient accepted. When patient goes to facility, he must be accompanied by a discharge summary.

6. Speech Center of Mercy College
555 Broadway
Dobbs Ferry, N. Y.
OW 3-4500
Diagnostic and remedial procedures in speech correction. Children through adults.

7. Westchester County Medical Center
Valhalla, N. Y.
592-8500 Mrs. Godfrey, social worker - rehab facility
This is a rehab facility for county residents. Fee is $225/day, as all medical services are available.
In order to apply for admission, medical abstract must be sent and family member should make an appointment to see facility.

8. Westchester Light House - N.Y. Association for the Blind
346 Mamaroneck Ave.
White Plains, N. Y.
761-3221
Services are available to all blind or visually handicapped persons in Westchester - regardless of age, sex, race, religion.

9. Manhattan

Institute of Rehabilitation Medicine (RUSK)
New York University Medical Center
400 East 34th St.
New York, N. Y. 10016

HOUSING

Kingsley House
41 Barker Ave.
White Plains, N. Y.
946-8080

163-unit, 12 story apartment building, specifically designed for middle-income elderly. Special safety features. Transportation available to railroad station and shopping within walking distance.

White Plains Housing Authority
223 Grove St.
White Plains, N. Y.
949-6462

Manages Winbrook Apts., low-rent project with 450 units in 9 story building, manages Lakeview Apts., 95 units, 50 specifically for elderly, in one building and Schuyler House, 167 units, 30 specifically for elderly in one building.

Young Men's Christian Association
250 Mamaroneck Ave.
White Plains, N. Y.
949-8030

Residential arrangements for men are available on both a temporary and permanent basis. Breakfast available.

LEGAL ASSISTANCE

Legal Aid Society of Westchester County
56 Grand St.
White Plains, N. Y.
761-9200

Offers legal assistance to persons with limited incomes in civil cases and in all criminal matters. No fees. Nothing specifically offered for elderly.

Westchester County Bar Association - Lawyers Referral Service
Room 22- 65 Court St.
White Plains, N. Y.
761-5151

Referral service for qualified lawyers. Especially useful for persons in need of legal advice who do not know how to locate a lawyer at moderate cost - public referral service. Fee $15. for initial half-hour consultation with a lawyer who is a member of the Westchester County Bar Association. A panel of 266 active, full-time practicing attorneys is involved in the program. No special services for the elderly.

White Plains Bar Association
175 Main St.
White Plains, N. Y.
949-5921

Referrals made to Legal Aid Society. No special services for elderly.

NUTRITION PROGRAM SITES

Greenburgh

Fairview Greenburgh Community Church
32 Manhattan Ave.
Greenburgh - White Plains
761-7124

Greenburgh/Dobbs Ferry

Embassy Club
60 Palisade St.
Monday & Wednesday
592-6200

Greenburgh/Tarrytown

Neighborhood House
43 Wildey St.

631-5990 Tues., Thurs., Fri.

Mt. Kisco

Moses Taylor Jr. Post
136 American Legion
1 Legion Way
Mt. Kisco, N. Y.
666-3059

Mt. Vernon

Mt. Vernon Sr. Citizens Center - Armory
144 N. 5th Ave.
Mt. Vernon, N. Y.
668-2200 X. 296

Model Cities Center
244 S. 7th Ave.
Mt. Vernon, N. Y.
668- X. 296

New Rochelle

Senior Citizen Center
Bancker Place
576-2600

New Rochelle Community Action Agency, Inc.
95 Lincoln Ave.
New Rochelle, N. Y.

Ossining

Washington School
83 Croton Ave.
Ossining, N. Y.

762-1311

NUTRITION PROGRAM SITES (cont'd)

Peekskill

United Methodist Church
Main St.
Peekskill, N. Y.
737-8544

Port Chester

St. Peter's Church
Pearl St. & Westchester Ave.
Port Chester, N. Y.
939-4975

White Plains

Grace Episcopal Church
33 Church St.
White Plains, N. Y.
948-9661

Yonkers

Salvation Army Community Center
110 New Main St.
963-1222

Messiah Baptist Church
74 Warburton Ave.
Yonkers, N. Y.
969-8161

Crescent Place Reformed Church
46 Crescent Place
237-7426

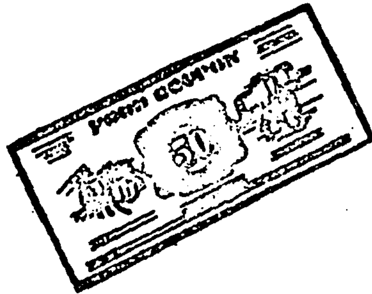
75¢ contribution if possible 60 years or older
Hot - noon meal call for reservations

CONSUMER ALERT

NEW FOOD STAMP ELIGIBILITY LEVELS

If your income is anywhere near these figures, you may be eligible for food stamps. All Public Assistance Families are automatically eligible for food stamps.

MAXIMUM ALLOWABLE NET MONTHLY INCOME
(Effective January 1, 1976)



No. in Household	Income
One	$ 215.00
Two	307.00
Three	433.00
Four	553.00
Five	660.00
Six	787.00
Seven	873.00
Eight	993.00

For each additional person, add $127.00

For information on the Food Stamp Program, call 682-2900.

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New Radio Program

County Executive Delbello has announced a new Radio Series for Senior Citizens, called "Westchester 60 Plus;" this is the same title as the County's Senior Citizen's publication. The Radio Program is devoted to keeping the County's Seniors well advised and informed about their rights and benefits, health, housing, employment and available ways to improve their life style. It is produced by the County Office for the Aging in cooperation with Station WFAS. The broadcasts can be heard on Station WFAS, Sundays at 9:35 P.M. and on Station WWYD, Saturdays at 7:00 A.M.

RECREATION

Community Action Program - Fairview Greenburgh Community Center
32 Manhattan Ave.
Greenburgh, N. Y.
682-5258

Provides activities for seniors, physical exercises, crafts, "live-together" club, nutrition program, advocacy, and recreation for seniors.

Special Recreation Services
Joseph Conway, Supv.
Westchester County Dept. of Parks, Recreation & Conservation
County Office Building
White Plains, N. Y.
682-2415

Sponsors some events specifically for senior citizens such as an annual boat trip, picnic and show.

White Plains Senior Citizen Center
25 South Broadway
White Plains, N. Y.
946-7722
Miss Debbie Paczkowski, Director

A multi-purpose facility with 8 activity areas including a cafeteria, main hall, lounge, boutique shop, library and 3 special program rooms. Activities include special events and trips, arts and crafts, choral and dramatic clubs, discussion groups, workshop, sewing, cards, bingo, etc. During the 5 day week there are also guest lectures, slides, educational courses.

Various Churches and Synagogues in the area have programs specifically for older people.

CLUBS

American Association of Retired Persons, Inc. (AARP)
Meetings once/month at Sr. Center cafeteria,
25 N. Broadway
White Plains, N. Y. Mr. Leo Magnotta, president
This is a national organization for retired persons, which includes social and volunteer activities. It sponsors publications of information and news for older people.

The Old Guard of White Plains
c/o YMCA
250 Mamaroneck Ave.
White Plains, N. Y. Mr. Weinstein, president
This is an organiaation of retired men who are over 60 years of age which meets at YMCA every Tuesday from 10 a.m. to 4 p.m. Purpose is diversion and assisting each other and community organizations by volunteer work.

Widows & Widowers Club of Westchester
470 Mamaroneck Ave. Room 302
White Plains, N. Y. 948-8804 Mrs. Jary Rapaport
Social, recreational and counseling program for widowed, including those over 60 years. Sponsored by the Family Service of Westchester, Inc.

TRANSPORTATION

Information:

1. Westchester County Department of Transportation
   Travel Information Service
   682-2020
   Provides information on any bus or train service within the county, Mondays through Fridays, 7 a.m. to 7 p.m.

   Farefree transit at specified bus stops available Mondays through Fridays 9 a.m. to 4 p.m. and on Saturdays, Sundays and holidays from 9 a.m. to 6 p.m.

2. Special Transportation for Senior Citizens
   Senior Citizens Center - White Plains
   946-7823 Mrs. Pierce
   A mini-bus is available to transport senior citizens free from any place in White Plains to any other location within White Plains.

VOLUNTEER OPPORTUNITIES

Burke Rehabilitation Center

785 Mamaroneck Ave., White Plains, N. Y. 10605
948-0050 Ext. 380 or 381
Mrs. Ina Schlobohm, Director of Volunteer Services
There are opportunities for volunteer work within the hospital.

The Day Hospital of Burke

785 Mamaroneck Ave., White Plains, N. Y. 10605
948-3303
The Day Hospital welcomes volunteers

Churches; Synagogues

Many churches and synagogues in White Plains provide opportunities for volunteer service by members of their congregations.

Family Service of Westchester, Inc.

470 Mamaroneck Ave., White Plains, N. Y. 10605
948-8004
This organization has opportunities for older persons to give volunteer services.

New York Hospital - Cornell Medical Center, Westchester Division

21 Bloomingdale Rd., White Plains, N. Y. 10605
949-8300
Contact: Director of Volunteers
There are opportunities for volunteer work with psychiatric in-patients.

Nursing Home & Extended Care Facility of White Plains, Inc.

37 DeKalb Ave., White Plains, N. Y. 10605
946-1440
Contact: Director of Recreation & Volunteer Service
There are opportunities for senior citizens to do volunteer work within this nursing home.

St. Agnes Hospital

North St., White Plains, N. Y. 10605
949-4000
Contact: Director of Volunteers
There are volunteer opportunities within this hospital.

Tibbits Health Care Facility

12 Tibbits Ave., White Plains, N. Y. 10606
428-0910
Opportunities exist here for volunteer work by older persons.

VOLUNTEER OPPORTUNITIES, con't.

Volunteer Service Bureau of Westchester, Inc.

470 Mamaroneck Ave., White Plains, N. Y. 10605
948-4452
Contact: Mrs. Margaret Moritz, Director
Mrs. Kit Lambert, Head of RSVP Program - 948-6069

The Volunteer Service Bureau has listings of agencies or persons needing services of volunteers and people available to interview perspective volunteers. They try to match interests and abilities of volunteers with needs of organization.

The Retired Senior Volunteer Program (RSVP) sponsored by this agency is a national program that involves men and women 60 years and over in volunteer programs in their own communities. This is done through formation of groups to go on a specific day to specific place to volunteer. Group transportation is provided from a central location as well as lunch on the day allocated to volunteers.

Westchester Association for Retarded Children

Chapter Headquarters
121 Westmoreland Ave., White Plains, N. Y.
949-9300
This organization provides volunteer opportunities in many areas.

Westchester County Medical Center

Volunteer Division - Director of Volunteers
Valhalla, N. Y. 10595
LY 2-8500 Ext. 2446
There are opportunities for older people to do volunteer work within the hospital. The RSVP Program busses elderly persons from Kingsley House one day each week.

White Plains Center for Nursing Care

220 West Post Rd., White Plains, N. Y. 10606
946-1440
Contact: Director of Volunteer Services
There are opportunities for senior citizens to do volunteer work within this nursing home.

White Plains Hospital Association

41 E. Post Rd., White Plains, N. Y. 10601
949-4500
Contact: Mrs. Joy Durham, Director of Volunteers
Opportunities exist in this hospital for volunteer work by older persons. Special project, utilizing carefully screened and trained older volunteers within Social Service Dept. of this hospital.

VOLUNTEER OPPORTUNITIES, con't.

White Plains Public School Volunteer Program

5 Homeside Lane, White Plains, N. Y. 10605
946-4200
Contact: Volunteer Coordinator
There are opportunities for persons over 65 to work as school volunteers. Activities include library work, clerical work and tutoring. Training is provided.

White Plains Senior Citizen Center

25 So. Broadway, White Plains, N. Y. 10601
946-7722
Senior citizens are offered the opportunity to do volunteer work within the Center and the Community.

APPENDIX E

LESSON PLAN FOR TRAINING PROGRAM

AREAS TO BE COVERED IN TRAINING PROGRAM

1. The Counselor-Assistant

Who is he?
Description of each person in the program.
Why has he volunteered?
Ascertain motivation of each.
Who are each of the counselor-assistants?
Discuss the role of the counselor-assistant as a hospital volunteer. What are his tasks and responsibilities.
Discuss counselor-assistant as a part of the Social Service Dept., with special emphasis on how he differs from a social worker and how his contribution is unique.

2. The Patient

Who are the patients?
How it feels to be a patient.
Problems encountered by the hospital patients.
Areas of concern to the patient

Chronicity	Fear
Disability	Regression
Death	Depression
Separation	Finances
Isolation	How to communicate with hospital personnel

Role of the counselor-assistant in relation to the patient.

3. The Hospital

Orientation - mission of the hospital.
variety of departments in hospital.
Tour facilities
Variety of services offered - nursing
P.T.
O.T.
X-Ray, etc.
Role of counselor-assistant in relation to the hospital.

4. The Community

Distribute resource manual.
Discussion of resources - rehabilitation hospitals, homemaker services, health facilities - HRF vs. SNF, office of aging, social security, medicaid, discounts, transportation, recreation, volunteer burea, employment, nutrition programs, senior centers
Role of the counselor-assistant in relation to community resources.

TRAINING PROGRAM

FIRST WEEK

Session I

10 - 11 a.m.: Welcome by Program Coordinator and Social Service Director

Discussion of the group as an elite one that is different from other volunteers. Speak about how they have been carefully selected and screened and how this program is unique, that we are counting on them to maintain commitment, etc., in order for us to obtain feedback and be able to research the program as a whole.

Allow people in group to introduce themselves and give their backgrounds and experience. Members of group to meet each other, discuss respective motivations in joining program. How do they view the program? What do they expect to get from it and give to it?

11 - 12 a.m.: Tour Hospital.

Have Joy Durham - Head of Volunteer office come up.

Discuss the connection with volunteer office.

Have volunteers sign up and get instructions on signing in each day, using parking lot, picking up uniforms, etc.

Meet with Social Service Dept. - workers, secretaries, see offices.

12 - 1 p.m.: Lunch with staff.

Discuss the department and the role of the counselor-assistant within it.

1 - 2 p.m.: Discuss how it feels to be a patient.

Draw on experiences of group members to bring up ideas in this regard.

Begin to categorize responses from group, ie: isolation, fear, concern about disability, death, etc.

Try to think of examples of what we have been talking about.

FIRST WEEK

Session II

10 - 11:30 a.m.: Continue discussion of patient.

How it feels to be ill and to be in the hospital, regression, need for care, dependency, disorientation, loss, death.

How the counselor-assistant can help in the areas suggested:

provide companionship.
listening to: complaints, concerns, fears, thoughts, reminiscences.
assist on concrete services.
provide linkage between patient, hospital and community.
provide information about hospital routines.
provide follow-up contact.
assist in specific tasks as requested by social worker.

Role-playing about helping hospital patient:

Discuss how to talk to patients and/or not to talk to patients.
Role of the counselor-assistant in relation to patient.
How to introduce self, ask questions.
How to listen - non-verbal communication
Touching
Where to sit or stand
How to obtain information
Confidentiality
Non-judgmental attitude

11:30 - 12:30: Lunch

Review and questions

12:30 - 2 p.m.: See patient together with social worker.

Introduce self - explain role.

Listen - how patient feels and problems he is encountering.

What to do - what not to do.

SECOND WEEK

Session III

10 - 11 a.m.: See patient alone.

Return and discuss experience.

11 - 12 a.m.: Orientation to hospital.

Discuss responsibilities of doctors, nurses, social workers, relationship of counselor-assistant to hospital personnel.

Talk by Head of Nursing.

Talk by patient representative.

12 - 1 p.m.: Lunch - review hospital setting and the place of the counselor-assistant within it.

Introduce forms and practice filling in.

Discuss feelings about seeing patients.

1 - 2 p.m.: How counselor-assistant can help patients in relation to hospital.

Can explain hospital routines, can accompany patients to other areas of hospital.

Speaker from U. R. Committee.

Case vignettes.

SECOND WEEK

Session IV

10 - 10:30 a.m.: Prepare to see patients - role-play.

10:30 - 11:30: Go to see assigned patients.

For new patient: introduce self
explain role
listen - how patient feels, problems he is encountering

For previous patients: talk
listen
be companion

11:30 - 12:30: Lunch.

Discuss experience - feelings about seeing patients.

Speak about own feelings aroused by particular patients, and about how the patient functions; problems encountered.

12:30 - 2:00: Discuss rehabilitation helps.

Speaker from P.T. Dept., explain the P.T. Dept. as well as O.T. and speech therapy.

Discuss rehabilitation hospitals in the area - what they do, who goes there.

Fill in forms regarding patients seen in morning.

Discussion with Home Care Dept.

THIRD WEEK

Session V

10 - 11:30 a.m.: Community resources

Financial helps: How hospital bills are paid.

Speakers from Medicaid, Social Security, private insurances

Discuss problems regarding finances.

How to apply for financial help, what it can cover and how eligibility is determined.

11:30 - 12:30: Lunch

Discuss financial aids: How to help patient obtain what he is entitled to.

12:30 - 2:00: See two patients who are assigned; discuss feelings about this.

Complete forms.

THIRD WEEK

Session VI

10 - 11:30 a.m.: Community resources - alternate living arrangements.

Institutions - Adult homes, S.N.F. and H.R.F. - what these are, who they benefit - describe.

Discuss feelings about nursing home placement for oneself, for others. Speak about philosophical stance and experience that members of group have had.

How to help patients accept reality of their situation.

What to look for in a home.

Financing nursing home care.

11:30 - 12:30: Lunch

Discuss experiences with patients.

Continue discussion of institutions for the aged.

12:30 - 2:00: See two previously assigned patients.

See a new patient. Re-convene and complete forms and discuss experience.

FOURTH WEEK

Session VII

10 - 12 a.m.: Meet, discuss seeing patients.

See three patients as seen before, or if not possible, see new patient.

12:00 - 1:00: Lunch

Further familiarity with resources and how and when to discuss with patients.

Give out resource manual and discuss how it is useful.

1:00 - 2:00: Discussion of homemaker services - fees, what they do, how to obtain.

Speaker from Office of Aging to talk about Information and Referral service, discounts, transportation, senior centers, recreation, etc.

FOURTH WEEK

Session VIII

10 - 11:30 a.m.: See three assigned patients.

11:30 - 12:30: Lunch

Discuss patients seen and feelings about being counselor-assistants.

12:30 - 2 p.m.: Discussion of life-threatening ilness and death
Concerns of patient, family, own experiences and feelings. How counselor-assistant can help.
Terminal cancer hospitals.

Discuss end of training.
Emphasis on roles of the counselor-assistant:
Follow patient over period of time
After patient is discharged from hospital, the counselor-assistant will follow-up to see how patient is doing.
Evaluate own reactions to the program.
Review what counselor-assistants will be doing and not doing.
How counselor-assistant works with social worker.

Point out schedule of sounselor-assistant upon starting the next week.

Meet with unit social worker.
See assigned patients.
Complete forms on patients.
Do other tasks for patients as suggested by social workers.
Make appropriate phone calls regarding patients.
Give data to social worker before leaving for the day.

APPENDIX F

HANDBOOK FOR COUNSELOR-ASSISTANTS

H A N D B O O K

for

C O U N S E L O R   A S S I S T A N T S

WHAT IS A SENIOR COUNSELOR-ASSISTANT?

A Senior Counselor-Assistant is a mature volunteer who works in the Social Service Dept. and has received special training in working with older patients. He or she is someone who can provide a link between the patient, the hospital and the community. He can do this because he is familiar with the time frame and generational level of the patients he sees and because of his training, is also knowledgeable about the hospital, the community around it and techniques of dealing with people.

The Counselor-assistant is to see older patients to help in their adjustment to the hospital and in their transition upon discharge. His work will be to help alleviate the emotional discomfort, fear, isolation and disorientation that can accompany hospitalization.

In order to do this he will do a variety of tasks under the direction of the hospital social workers.

WHAT ARE THE POSSIBLE TASKS OF THE COUNSELOR-ASSISTANT?

You will be doing a number of things to help the older hospital patients to whom you are assigned. You will visit the patient, introduce yourself and explain your role and discuss hospital routines and their effect upon the patient.

You can sometimes help the patient just by listening; by allowing patient to express feelings, to reminisce, to complain or to ask questions. You can sometimes accompany the patient if he must go to another part of the hospital. It can help the patient to have someone to wait with before having X-rays, physical therapy, etc.

You will be forming a relationship with specific patients and will also obtain concrete information from them with regard to their age, condition, living situation, financial situation, family involvement, daily activities at home and concerns regarding the hospital or discharge planning.

TASKS - con't

You will be asked to complete specific forms on each patient to help in evaluating this pilot project. Under direction of the unit social worker, you may also help complete some of the papers needed by the patient.

Under direction of your unit social worker, you may be able to suggest appropriate community resources for patients and when appropriate, may be speaking to some family members.

You will meet with your unit social worker and will attend group meetings to discuss your work and give feedback about the program.

WHAT SHOULD THE COUNSELOR-ASSISTANT NOT DO?

You should never get involved in giving medical advice, or in telling patients about their medical condition.

In no way should you undermine the care given by the physician or nurses. Any questions you have in this regard should not be broached to patient; but can be discussed with unit social worker.

Do not get caught up in giving false assurances.

Do not try to be a psychotherapist.

Do not take any action without discussing it with your unit social worker.

Do not make assessments to the patients of their condition or needs. Rather share your ideas with the unit social workers and act upon suggestions made in conjunction with the social worker.

WHICH PATIENTS WILL THE SENIOR COUNSELOR-ASSISTANT SEE?

You will be seeing patients in the hospital who are over 60 years of age, and are assigned to you by the unit social worker or program coordinator.

The people you will be asked to see will be as different from each other as every person is from every other. The fact that two people may be suffering from the same disease does not mean that their response to the illness is the same, or their concerns will be matched.

Each person is an individual with specific background, family configuration, life experience, etc., and the relationship you form with each will be unique.

WHAT KIND OF TRAINING DOES THE COUNSELOR-ASSISTANT RECEIVE?

Training for your role as a counselor-assistant will be given during four (4) weeks. There will be two (2) sessions per week. Each will last four hours and will include lunch. Training will include orientation to the hospital, information about community resources and work on building skills in listening, empathizing, ascertaining specific information and maintaining confidentiality.

During this period, there will be discussions, speakers, acting out the counselor-assistant role, practice in working in the hospital and supervised contact with patients. You will be able to become more comfortable in dealing with feelings about illness and in actually speaking to patients.

WHAT SUPERVISION IS PROVIDED FOR THE COUNSELOR-ASSISTANT?

Each counselor-assistant will initially be supervised by the program coordinator and social service director. After the introductory period, you will be assigned to a specific unit and will work with the social worker assigned to that unit.

Group meetings, including all the counselor-assistants and the program coordinator will be scheduled regularly to enable sharing of experiences and discussion of feelings and techniques.

WHAT ARE THE HOURS AND PROCEDURES FOR SIGNING IN AFTER TRAINING PERIOD IS ENDED?

Each counselor-assistant will be expected to give four (4) hours on each of two (2) days to working in the hospital. You will be working on a specific hospital unit and with a specific social worker. Once your days and hours are agreed upon, you will be expected at those times. If you cannot come at your regular time, you will be expected to call the Social Service Dept. and try to arrange to come in a different time.

Each time you arrive at the hospital, you will sign in at the Volunteer Office and then check in with the Social Service Dept. While you are in the hospital, you will see your assigned patients, fill in necessary forms on each and handle other tasks as appropriate for your patient.

Time will be made available for supervision and group meetings.

WHAT ARE THE REWARDS OF BEING A COUNSELOR-ASSISTANT?

The counselor-assistant is a very special person. You have been chosen for this role because of the attributes and interest you have and the life experience you bring. You can enjoy the stimulation of learning new knowledge and skills and participating as part of a professional team in a vital service. You can enjoy knowing that you are making a significant contribution.

A most important reward is the satisfaction that comes when you actually help other people. To have given of your time, interest and concern to another in a skilled manner does lead to very real personal satisfaction.

APPENDIX G

CERTIFICATE OF COMPLETION OF TRAINING

WHITE PLAINS HOSPITAL

SOCIAL SERVICE DEPARTMENT

AWARDS THIS CERTIFICATE

TO

FOR COMPLETION OF A TRAINING PROGRAM AS
A SENIOR COUNSELOR-ASSISTANT

PROGRAM DIRECTOR

DIRECTOR OF SOCIAL SERVICE

APPENDIX H

COPIES OF PUBLICITY RELEASES

Lifestyles / part II

THE REPORTER DISPATCH, White Plains, N.Y., Wed., July 28, 1976

Program's aim: Seniors helping seniors

Seven volunteers at the White Plains Hospital, all recent graduates of an intensive four-week training course, will be part of a pilot program aimed at having seniors help seniors.

Officially called the Senior Volunteer Counseling Assistant Program, the hospital has trained senior volunteers to work specifically with senior patients in hopes of "bringing together two groups of people who can benefit each other greatly."

Under the direct supervision of a social worker, the six women and one man will work eight hours a week at the hospital. During each of their two four-shifts, it will be the volunteers' job to see older patients and help them adjust to the hospital.

Mrs. Susan Blumenfield, designer and coordinator of the project, explained that because of their training, age, interest and experience the senior counselor assistant can possibly help alleviate discomfort, fear, isolation and disorientation older patients experience during hospitalization. "The ability to listen and to empathize is one of the most important qualifications," said Mrs. Blumenfield who designed the project as part of her doctoral studies in social work.

Abraham Yellin of Yonkers, who retired after working as a pharmacist at Cross County Hospital, is the only man to earn a certificate for successfully completing the 30-hour training course. Yellin learned about the idea when Mrs. Blumenfield spoke to the sixty-plus club at ph Weinstein and Mrs. Joseph Noon, all of White Plains. Mrs. Vera Blake of Harrison and Mrs. Mary Mullin of Greenwich, Conn. also were certified as senior counselor assistants.

Beryle Friese, assistant executive director of the White Plains Hospital said, "The hospital is indeed fortunate to have such a group."

"As we have been examining the age of our patients in connection with our long range planning, we find that we have more and more people in the area in the older age bracket. That means we will be seeing more and more older patients. The volunteers will be making a significant contribution by helping us take care of the needs of these patients."

Saw Mill River RECORD • Pleasantville, N. Y. July 28, 1976

Seniors aid patients in new program

Seniors helping seniors is the idea behind a new pilot project at White Plains Hospital. Officially called a Senior Volunteer Counseling Assistant Program, it brings together two groups of people "who can benefit each other greatly," according to the Hospital's Director of Social Services, Mrs. Carol Rocklin.

Seven volunteers assigned to the Department of Social Services are the first to complete four weeks of training as counselor assistants. Their job is to see older patients and help them adjust to the hospital by allowing them to express feelings that might not be brought out in the usual interview.

Beryl Friese of Pleasantville, Assistant Executive Director of White Plains Hospital, presented certificates to the group, and said, "The Hospital is indeed fortunate to have such a group. We find that we have more and more people in the area in the older age bracket, which means we will be seeing more and more older patients. You will be making a significant contribution by helping us take care of the needs of these patients."

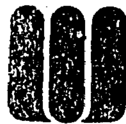
Susan Blumenfield, designer and coordinator of the project, described the Senior Counselor Assistant as someone who, because of age, interest, personal attributes, experience, and training, can help alleviate the discomfort, fear, isolation, and disorientation accompanying hospitalization for older patients.

The 30 hour training course included orientation to the Hospital, information about community resources, work in building skills in listening, gathering specific information and maintaining confidentiality.

Mrs. Blumenfield designed the Senior Volunteer Counselor Assistant program in connection with her doctoral studies. The hospital will continue the program beyond the duration of the pilot study, and new volunteers will be recruited and trained as they are needed.

Westchester60

An Information Letter for Senior Citizens — Fall 1976



Westchester County

Published by the Office for the Aging
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Orial A. Redd, Ass't to
County Executive/Human Development
Joseph A. Tortelli, A.C.S.W.
Director, Office for the Aging
Lewis Greenwood, Editor

This document is published under Project Number 11778 with the New York State Office for the Aging under Title III of the Older Americans Act of 1965, as amended.

A Hospital Meets More Than Medical Needs- You Could Take Part!

"PEOPLE WERE RUNNING in and out all day, doing things to or for me, but I still felt very alone in the hospital." "It was confusing, changing rooms, having tests. Never quite understanding what was going on." "I don't think anyone really understood what it meant to be so afraid." Words such as these are frequently heard from older hospital patients.

People come to hospitals at times of medical crises. The main mission of any acute care hospital is to deal with and alleviate these crises. Hospital personnel do this as effectively, efficiently, and humanely as possible. Yet, though the medical needs may be met, there is often neither time nor resource to meet the social and psychological concerns of patients. Seniors often find themselves needing more medical care than they did earlier in their lives, are often particularly hard-hit by this lack. Important linkages between the patient, his family and community resources break down when the older person is hospitalized. Establishing these balances would be a great service.

Such older patients need someone to encourage and assist them in establishing good communications with medical personnel. They might need help in identifying the existence of special resources and occasionally require future assistance in utilizing them.

continued on page 7 column 3

Hospital meets..

Many need someone to lis
pathize when other needs ha
To address this need, a P
Mental Health Association
implemented by White Plai
an attempt to involve, as vo
resource of capable retire
years of age could bring
would be helpful to Senior
with similar life experience
empathize with older hospi
be alert to discovering ge
people as well.

Volunteers were recruit
assistants in the Social Se
Hospital. The selected volu
to-one basis with older pa
giving companionship, psy
crisis of illness and infor
community resources. The
sensitive to feelings of oth
confidentiality.

All volunteers participa
course, given 4 hours a
cluding knowledge about
resources and the devel
terviewing and listening. T
to begin working directly
training period. Following
give 2-4 hour sessions per w
of at least 3 months. On
social workers, including
provided.

It is the hope at Whit
utilizing the resources of t
isolation, fear and disor
accompany hospitalization,

Anyone who would be in
program or in giving th
number for possible inclu
please call 949-4500, Ext.
Mrs. Susan Blumenfeld,
Mrs. Carol Rocklin, Dire
White Plains Hospital.

ster 60 plus

r Senior Citizens — Fall 1976

Hospital meets...

continued from page 6

Many need someone to listen, understand and empathize when other needs have been met.

To address this need, a Pilot Project initiated by the Mental Health Association of Westchester is being implemented by White Plains Hospital. This project is an attempt to involve, as volunteers, part of the large resource of capable retired adults. People over 60 years of age could bring specific attributes which would be helpful to Senior patients. Such volunteers with similar life experiences can readily identify and empathize with older hospitalized patients. They can be alert to discovering generalized needs of these people as well.

Volunteers were recruited to act as counselor-assistants in the Social Services Department of the Hospital. The selected volunteers will work on a one-to-one basis with older patients. They will help in giving companionship, psychological support in the crisis of illness and information about appropriate community resources. The volunteer had to be tactful, sensitive to feelings of others and able to maintain confidentiality.

All volunteers participated in a 4-week training course, given 4 hours a day, twice a week and including knowledge about the hospital, community resources and the development of skills in interviewing and listening. The volunteers will be helped to begin working directly with patients during this training period. Following this, the volunteers will give 2-4 hour sessions per week on the job for a period of at least 3 months. Ongoing supervision by staff social workers, including group discussions will be provided.

It is the hope at White Plains Hospital that by utilizing the resources of the trained older adult, the isolation, fear and disorientation which so easily accompany hospitalization, will be reduced.

Anyone who would be interested in reacting to the program or in giving their name and telephone number for possible inclusion in a future program, please call 949-4500, Ext. 2079 and ask to speak to: Mrs. Susan Blumenfeld, Program Coordinator, or Mrs. Carol Rocklin, Director of Social Services for White Plains Hospital.

APPENDIX I

FORMS COMPLETED BY COUNSELOR-ASSISTANTS ABOUT PATIENTS

PATIENT FACT SHEET

1. Name ______________________________
2. Address ______________________________
3. Age ______
4. Sex ______
5. Race ______
6. Religion ______
7. Diagnosis ______________________________
8. Physician's Name ______________________________
9. Unit ____ Room ____
10. Admission Date ________
11. Private duty nurses? ______
12. Amount of visiting by relatives, friends ______________________________

    ____
13. Social Service rendered ______________________________

    ____

    ____
14. Discharge plan ______________________________

    ____

    ____
15. Discharge Date ________
16. Length of stay ______

Patient Name:

DAILY CHECK LIST FOR COUNSELOR-ASSISTANT

DATE						
Talked to Patient						
Spoke to Family						
Brought things to Patient						
Made calls for Patient						
Called other agencies						
Helped with Forms						
Suggested Community Resources						
Accompany pt. to other parts of hosp.						
Conferred with Soc. Worker						

AREAS COVERED in TALKING with PATIENT

Area	
The Weather	
The Hospital	
Patient's Condition	
The Physician	
The Nurses	
Patient's Family	
Patient's Friends	
Financial Concerns	
Future Plans	
Reminiscences	

AREAS COVERED in TALKING with PATIENT

	Nurses
	Patient's Family
	Patient's Friends
	Financial Concerns
	Future Plans
	Reminiscences
	Food
	Other

DAILY CHECK LIST FOR COUNSELOR-ASSISTANT

C.A.

						...for Patient
						Called other agencies
						Helped with Forms
						Suggested Community Resources
						Accompany pt. to other parts of hosp.
						Conferred with Soc. Worker
						Made follow-up calls
						Wrote or read letters for
						Other - explain

APPENDIX J

RATING FORMS COMPLETED BY SOCIAL WORKERS

Patient's Name ________________

1. Was the Counselor-Assistant helpful to the patient in any of the following ways?		Detrimental	Not Helpful	Made No Difference	Somewha Helpful
a. Provide companionship to patient	1a.				
b. Orient pt. to hospital routines	1b.				
c. Accompany pt. to areas of hospital	1c.				
d. Alleviating feelings of depression	1d.				
e. Alleviating fears of patient	1e.				
f. Provide continuity for patient	1f.				
g. Helping to fill out forms	1g.				
h. Other (What)	1h.				
2. Was the Counselor-Assistant able to assist you in specific tasks?					
a. Speaking with patient	2a.				
b. Speaking to patient's family	2b.				
c. Speaking to hospital staff	2c.				
d. Contacting doctors	2d.				
e. Contacting community agencies	2e.				
f. Completing forms	2f.				
g. Other (what)	2g.				
3. Was the Counselor-Assistant helpful to other individuals associated with this case? To what degree?					
a. To the patient	3a.				
b. to the patient's family	3b.				
c. " " nurses	3c.				
d. " " doctors	3d.				
e. " " goals of the hospital	3e.				
f. Other (which)	3f.				

Patient's Name ________________

Was the Counselor-Assistant helpful to the patient in any of the following ways?		Detrimental	Not Helpful	Made No Difference	Somewhat Helpful	Very Helpful
companionship to patient	1a.					
ɔt. to hospital routines	1b.					
ıy pt. to areas of hospital	1c.					
;ing feelings of depression	1d.					
;ing fears of patient	1e.					
continuity for patient	1f.					
to fill out forms	1g.					
'hat)	1h.					
Was the Counselor-Assistant able to assist you in specific tasks?						
; with patient	2a.					
; to patient's family	2b.					
· to hospital staff	2c.					
ng doctors	2d.					
ng community agencies	2e.					
ng forms	2f.					
hat)	2g.					
Was the Counselor-Assistant helpful to other individuals associated with this case? To what degree?						
atient	3a.					
atient's family	3b.					
urses	3c.					
octors	3d.					
oals of the hospital	3e.					
ich)	3f.					

4. Did the Counselor-assistant follow up on the patient after discharge? Yes ____ No ____

If yes, what did the counselor-assistant do? ______________

____

____

5. Were there specific problems in working with the counselor-assistant? Yes ____ No ____

If yes, in which of the following ways were there problems?

Lack of training ________

Asst's Personality ________

Asst's Age ________

Asst's Sex ________

Structure of the hospital ________

Hours in which asst worked ________

Other ______________

____

6. If there were any, is there some way the problems with the counselor-assistant could have been handled or could be averted in the future?

____

____

____

APPENDIX K

QUESTIONNAIRE COMPLETED BY PHYSICIANS AND NURSES

1. Are you aware of the counselor-assistant program which is being tried at this hospital?

   Yes ___
   No ___

2. Have you had any contact with any of the counselor-assistants?

   Yes ___
   No ___

3. Did any of your patients have contact with a counselor-assistant?

   Yes ___
   No ___

4. If "Yes" to #3, did you feel that the counselor-assistant was helpful to your patients?

   Yes ___
   No ___

   In what ways were the counselor-assistants helpful?

   ____

   ____

   ____

   ____

5. To what extent have your patients found the counselor-assistant helpful?

   patient felt very much helped ___
   patient felt somewhat helped ___
   counselor-assistant made no difference ___
   counselor-assistant gave no help ___
   counselor-assistant was detrimental ___

6. Do you feel that patients who received the services of a counselor-assistant experienced less fear, disorientation or feelings of isolation than those who did not have this service?

   Yes ___
   No ___
   Don't Know ___

7. Do you have any questions about the counselor-assistant program?

   ____

   ____

8. Do you have any suggestions that m ight be helpful in improving the counselor-assistant program?

____

____

____

APPENDIX L

QUESTIONNAIRE COMPLETED BY COUNSELOR-ASSISTANTS

EVALUATION OF PROGRAM

1. Have you enjoyed working in the program?

2. What things in the program made it particularly pleasant for you?

3. What personal needs of your own are satisfied by working in the program?

4. What things have made it particularly difficult?

5. How would you define your role as counselor-assistant?

6. Was the training program useful in your role as counselor-assistant? How?

7. What do you get out of supervision by the social worker?

8. How could this supervision be improved?

Evaluation of Program - page 2

9. What impact, if any, has contact with other hospital staff had upon you in the program?

10. What, if anything, do you derive from the group meetings?

11. How could these be improved?

12. What do you feel that patients get out of your contact with them?

13. Please give your overall opinion of the concept of sounselor-assistants in the hospital setting.

APPENDIX M

STRUCTURED INTERVIEW FORM FOR PATIENTS

INTERVIEW SCHEDULE FOR PATIENTS

Name:

1. Are you aware that in this hospital you were assigned a special volunteer called a counselor-assistant, to help you during your stay here?

   Yes ___

   No ___

2. If yes, approximately how often would you say you spoke to the counselor-assistant?

   Never ___

   One Time ___

   A Few Times ___

   Quite Often ___

   Very Frequently ___

3. Did the counselor-assistant aid you in any of the following ways? How helpful was he or she?

	Very Helpful	Somewhat Helpful	Not Helpful
Friendly conversation			
Explained Hospital routines			
Brought things you needed			
Made calls for you			
Went with you to other parts of the hospital			
Helped you with forms			
Spoke with your family			
Suggested helpful community resources			
Gave information to decrease your worries			
Read or wrote mail for you			
Other			

4. In what ways would you have liked help, which the counselor-assistant did not provide?

____

____

____

5. Are there ways you can think of, even though you didn't need such help, that the counselor-assistant might be helpful to other patients?

____

____

____

6. Would you recommend that we keep the program of using counselor-assistants to help hospital patients?

Yes ___

No ___

Could you explain? ______________________________

____

7. Other comments:

____

____

____

____

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