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The design and implementation of a telephone information and referral service

Blaustein Goodman, Barbara, D.S.W.

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300 N. Zeeb Rd.
Ann Arbor, MI 48106

THE DESIGN AND IMPLEMENTATION OF A TELEPHONE INFORMATION AND REFERRAL SERVICE

by

Barbara Blaustein Goodman

A dissertation submitted to the Graduate Faculty in Social Welfare in partial fulfillment of the requirements for the degree of Doctor of Social Welfare

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6/27/94
Date

Mildred D. Mailick
Chair of Examining Committee

6/27/94
Date

Harold Weissman
Executive Officer

Charles Guzzetta

Harold Weissman

Michael A. King

Supervisory Committee

THE CITY UNIVERSITY OF NEW YORK

Abstract

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by

Barbara Blaustein Goodman

Advisor: Professor Mildred D. Mailick

Conflict in values emerge when an agency's goals of meeting community needs and filling gaps in services are confronted by budgetary constraints. As one means of harmonizing these issues, this project was undertaken to demonstrate the feasibility, efficacy, and cost effectivenss of a telephone information and referral (I&R) service staffed by volunteers. Relevant literature is reviewed. Project methodology is described. Findings are summarized. Recommendations are discussed.

The project was undertaken in order to explore the use of a telephone I&R service in order to provide information to the community. This service was to address the mission of the American Heart Association, Nassau Region to provide a distinct measurable service to the community in a caring and cost effective manner; to relieve the busy agency staff of the responsibility and chore of speaking to those with problems; to provide information; to engage in education and prevention activities; to identify client needs; to identify needs and gaps in service; and to enhance the positive relationships between the

agency and the public. This service went beyond providing information, as it offered the caller an opportunity for interactive exchange that may have ramifications for assistance beyond concrete I&R. It provided access, immediacy, and personal attention, without fee, to the general public, and permitted callers to control the extent to which they could remain anonymous, if they wished. Information, referral, and assistance were provided in a cost efficient and effective manner utilizing the manpower of trained volunteers supervised by a professional. It was organizationally manageable and evaluable.

Based on the analysis of the service, a number of recommendations is appropriate. Agency commitment and institutionalization are essential, as well as continual screening, recruitment, and training of volunteers. I&R services might provide a valuable field work experience for BSW students or human service program students. This project serves as a model that could be replicated in a variety of settings or as a basis for the development of a centralized telephone I&R service.

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I. INTRODUCTION

Background

The American Heart Association (AHA) dedicates all its activities to one goal: "the reduction of premature disability and death caused by cardiovascular disease" (American Heart Association, 1986, p. 1). To achieve its goal, the AHA funds research, distributes literature, conducts educational programs, promotes heart-saving activities, participates in health fairs, and supports initiatives of its state affiliates. It encourages state affiliates "to consider whether to develop Information Service or Information and Referral Services. The purpose of both kinds of service is to bring together community resources and the people who need them" (American Heart Association, 1980, p. 4). As the authoritative source of information on cardiovascular and cerebrovascular disease, the American Heart Association is called upon for its knowledge not only by health professionals and agencies but by community people as well. One reaction to the quest is the AHA's promotion of Heart Information Services. "Heart Information Service is a basic and continuing obligation of every Heart Association, related to all other aspects of the Heart Program and reaching deeply into community life. This service forms part of the fundamental structure of the Heart Association's programs" (p.1). In furtherance of this position, the American Heart Association Information Services Program Guide was developed.

State affiliates of the AHA encourage and oversee activities of local offices. In New York State, one local office is the American Heart Association, Nassau Region (AHA, Nassau Region).

The AHA, Nassau Region office, in furtherance of the Association goals, raises funds, sponsors educational programs for health professionals, conducts training sessions and conferences for lay people, distributes literature and a newsletter, and undertakes other informational activities. One of the major activities is to educate and inform the public and to refer inquiries to appropriate sources. This latter function goes under the general title of Information and Referral (I&R).

Throughout its history the American Heart Association directly from its national office has utilized and depended heavily upon volunteers. Typically these volunteers comprise retired or disabled individuals, professional men and women and others. Volunteers help with clerical tasks, give pro bono technical, therapeutic, programmatic and organizational assistance, assist in committee work, and in other ways.

Rationale and context

The writer will hereinafter be referred to as program coordinator. Prior to the design of the project, the program coordinator became a member of the Psychosocial Committee of the AHA, Nassau Region. This agency desired an Information and Referral service which the program coordinator, serving in a volunteer capacity, was able to design, implement and administer.

The design of the project took approximately nine months. The project ran for one and a half years during which time data were obtained. In the months following, the data were evaluated and conclusions drawn.

The Social Work field has sought to find more cost effective ways to deal with clients and to increase their comfort in obtaining services. In recent years, the use of a "telephone information and referral service" is often cited in the literature as fulfilling these aims. Authors such as Kahn (1976), Roston (1980), Hornblow (1986), and Levinson (1988a) discuss telephone usage in the areas of prevention, health information, counseling, and I&R. In addition, the utilization of volunteers in a variety of programs and services has received much attention, as discussed by Ross (1983), Schwartz (1984), Chambre (1987), and Levinson, (1988 a,b). The project described here is a systematic study of an effort to create and to make an objective determination of the efficacy of such a service.

The project report reviews literature bearing on Information and Referral. It discusses the design and implementation of a telephone information and referral service administered by a professional social worker using trained volunteers in a structured environment. It explores requirements to make an effective ongoing service a reality. It further discusses volunteer recruitment, training, supervision, and updating resource information.

Setting

The AHA, Nassau Region is located in Mineola, New York, a Long Island community approximately twenty-five miles east of New York City. The office building is in a suburban neighborhood, facing a thoroughfare lined with commercial businesses, and bordered by residential homes and government offices. Because the building was

originally a home that was converted into office space, it has long been a familiar part of the community landscape. The location is central to its catchment area, which consists essentially of single-family residences, garden apartments, and condominium or cooperative complexes, an area of about four hundred square miles. The area is poorly served by public transportation. When the project was under consideration, the personnel consisted of twenty individuals including an Executive Director, program directors, their assistants, and clerical staff.

The AHA, Nassau Region noted that in-patient hospital cardiac units were bombarded with calls for information about cardiovascular disease, from patients, relatives and many individuals with no prior association with the unit. Hospital staff complained that the volume of inquiries interfered with the provision of direct care to cardiac in-patients.

In the late 1970's, a Psychosocial Committee (the "Committee") was appointed at the AHA, Nassau Region to address this and other problems. Members were physicians and nurses representing various local hospitals. Gradually, social workers and psychologists were added to the committee.

The Psychosocial Committee determined that the office should initiate an I&R service to respond to the requests from the community. The local Director of the Nassau County Department of Public Health Social Work was invited to attend one of the meetings of the Psychosocial Committee to discuss development of an I&R service, since the Health Department already had one in operation in the public sector. It was understood that exclusive focus at the AHA, Nassau Region would be on cardiovascular

disease and would not duplicate Health Department efforts. Encouraged by the Health Department's response, the committee asked the Director and the Commissioner of Health to present their I&R operation to the American Heart Association's Board of Directors. Following the presentation, the Board agreed that the program had potential for adaptation to AHA, Nassau Region use. The Psychosocial Committee was charged by the AHA, Nassau Region to design and staff an I&R service. The Director of Public Health Social Work was invited to participate on the Committee and, in fact, became instrumental in designing the program.

About this time, the AHA, Nassau Region initiated a "Heart and Stroke Information Service" in cooperation with hospitals serving county residents. Several of these hospitals provided grants to help launch the program. AHA, Nassau Region hired a social worker with no support staff to develop and operate an I&R program. An office and a telephone were provided along with supplies. This social worker soon resigned, leaving no social worker to cover the service for several years. Eventually, a part-time social worker was hired to revive the I&R service. A year later the service was eliminated by the newly hired Executive Director. The Psychosocial Committee was disbanded as well. A few weeks after this, the Executive Director was replaced by a new Executive Director. The social worker who had been operating the I&R Service approached the revitalized Pyschosocial Committee and proposed reinstatement of an I&R Service. She joined the Committee and after some months, the decision was made to open an I&R Service, led by the social worker.

After several years of false starts and program changes, the design, implementation, administration, and evaluation of an I&R program for the AHA Nassau, under sanction of the Psychosocial Committee, Executive Director, and Board was approved and begun. Problems that needed to be considered were in the design, staffing, space, and cost. Design issues included coverage, advertising to the community, and no cost accessibility for the public. The design needed to meet the demands of the office that was operating without an institutionalized, organized and systematic program. The design also needed to address the type of I&R service to be provided as there is a range of services that potentially could be offered. The Executive Director had no funds available to hire a professional or any other worker to operate and monitor the program, nor did he intend to provide present office personnel to be involved in the program, other than for secretarial needs. Office space which afforded privacy, and access to a telephone were necessary. The cost of telephone usage, supplies, refreshments, secretarial time, availability of literature, and mailings needed to be addressed. The proposal for organization and operation of the program was accepted as a doctoral project.

II. LITERATURE REVIEW

Information and referral systems

1. Definitions

Among lexical definitions of "information" and "referral" are those which briefly delineate the intent of the project herein described: "information...a person or agency answering questions as a service to others;" "1. referral...a referring or being referred as for professional service, etc. 2. a person who is referred or directed to another person, an agency, etc." (Webster's New World Dictionary, 1988, pp. 433, 719).

According to Long (1979), an Information and Referral service in social work/social welfare is an "organizational entity" passing information along to those seeking it. The general intent of I&R is to connect those in need to a resource while identifying gaps in services and programs (Long, 1979). Risha Levinson (1988a) offers the following: "I&R is an organized set of systems of services, agencies and/or networks that aims to facilitate universal access to human services. Through the use of an updated and readily retrievable resource file, trained I&R staff link inquirers in need of information and/or services to appropriate resources in accordance with acceptable standards of professional practice. Of equal importance to direct client services is the capacity of I&R to provide a reliable and retrievable database for advocacy, policy, program, and social planning in the interest of promoting and improving access to human services " (p. 9).

Austin (1980) believes that the nature of the I&R service is defined by how the service responds to clients. As an example, he queries as to what extent should the person responding over the telephone try to clarify a problem instead of continuing based upon the caller's initial statement of the problem. Other questions posed include: to what extent

should I&R follow through with a referral; how much identifying information should be sought; and should an office interview be arranged. The scope of the service needs to be defined.

Levinson (1988a) discusses various types of I&R services, including those designed to deal with a specific health areas. There are similarities and differences between an information service and an information and referral service. A key AHA manual asserts that "both bring together community resources and people who need them. Both can bring into focus community problems affecting heart and stroke patients and their families, revealing gaps and overlapping of services. Information services encompass a program of providing information. I&R goes further in providing for services comparable to social casework. The distinction between the two services is that of depth and extent to which social work skills are needed. Much overlap exists between services" (American Heart Association, 1980, p. 4).

2. Historical development

Social Service Exchanges were an historical link for the creation of I&R programs of the 1900's (Levinson, 1988, a&b). These exchanges, started in the 1870's during the charity organization movement, were meant, in theory, to enhance communication among agencies. In an effort to avoid duplication of service, a centralized file of clients known to social service agencies was maintained. In later years, its main purpose was to coordinate service efforts for clients. Member agencies were able to ascertain if a client was known to other member agencies. The exchanges developed policies and procedures which

included membership, personnel requirements, policies on financing, interpretation, and liaison with member agencies (Williams, 1964). Long (1973) claims that the exchanges prevented rather than facilitated client access to human services. However, they did provide agencies with ready access to important data.

A professionally qualified social worker and competent clerical staff were identified as the minimum staff to operate the service. The social worker was expected to assume executive responsibilities which included organization and development of the exchange, supervision of clerical staff, work with boards or advisory committees, maintaining contact with agency members and participating in community welfare councils and other places to relate the program to the community (Williams, 1964).

A central body (United Community Funds and Councils of America, UCFCA), served as a clearing point of information regarding social service exchanges. Through mailings and site visits, this body facilitated the development or changes to exchanges and communities (Williams, 1964).

The number of exchanges diminished considerably in the U.S. and Canada from 320 in 1946 to 97 in 1963 (Long, 1973). The Directory of Social Service Exchanges reported 40 exchanges in 1969. Eight of these were identified as I&R centers as well (Levinson, 1988a). Although consolidation of exchanges was cited as a possible cause for the decline, other reasons were given such as changes in casework philosophy, increasing costs, specialized agency functions, and less use. Williams (1964) suggests that these reasons may have been seen as symptoms of the exchange not being a necessary entity. This lent itself to the review of developments in the social work arena. The need for

clearance to avoid service duplication had lessened with a rise in integrated public welfare agencies. It was also felt that it was preferable to elicit information directly from a client rather than obtain dated information from another source. In addition, ethical and confidentiality issues were raised about the use of the shared information.

Although opinions at the time (1952) varied as to the value of the social service exchange, there was virtual consensus of the importance of agency networking in the utilization of resources on behalf of clients (Williams, 1964).

The exchanges were being phased out in the 1940's as other I&R services were being formulated during the time the exchanges were still widely used (Long, 1973). A New York City agency executive director pointed out the advantages of the Citizens' Advice Bureaus (CAB) in England (prior to 1965) advocating a similar model in the United States (Zucker, 1965).

The CAB was started in England in 1939 by the (British) National Council of Social Service in anticipation of emergencies and family crises that could emerge from the impending second world war. The offices were located wherever space was available including settlement houses, family casework agencies, stores, and libraries, and was staffed by social workers and volunteers. The CAB was financed by the Ministry of Health. It served as a place of help and information to individuals and the government. Through the years since World War II, it has been able to note trends or needs in communities and provide service during normal times (Zucker, 1965).

In 1948, the "Beveridge Plan" was a major social welfare legislation enacted in England with other social reforms. Lord Beveridge advocated that the CAB's be financed

by the government, but must be autonomous. He felt the CAB's could help the public about using services as well as advocate and protect their rights (Zucker, 1965).

The trend was toward a generic-based access system. However, due to the need for specialized information, there was a shift toward increased specialization in the 1980's. Their predominantly volunteer operated staff was enhanced with specialists in other areas such as marital and family counseling, welfare benefits, housing, and consumer affairs (Levinson, 1988a).

In 1966, Alfred Kahn, following a visit to England, published Neighborhood Information Centers. His report, apparently influenced by his observations of the CAB work, describes small local social welfare facilities that have the capacity to deliver selected services. He proposes centers that accept responsibility for informing clients of services appropriate to their needs and to make referrals, thus facilitating the coaptation of problem and solution (Kahn, 1966).

Efforts to build I&R offices grew in the 1960's. The United Community Funds and Councils of America, (the predecessor national organization of the current United Way of America), showed interest in I&R services. Central staff personnel were involved in the creation of a clearing house for reports of I&R centers sponsored by local United Way agencies as well as the development of training materials, workshops, and development of standards for the provision of I&R services (Long, 1979). In 1972, there were approximately sixty I&R centers listed under the auspices of the United Way of America, many of which had their origins with the social service exchanges. Their resource files contained information related to social welfare resources, but later were expanded to

include the fields of health and aging due to the development of the Public Health Service Chronic Disease Program in the early 1960's (Long, 1973).

Information, referral, and follow-up services were deemed as its basic program for the National Easter Seal Society and its affiliates in 1966 (Long, 1973). However, due to opposition of this program by affiliates many did not fully undertake the implementation of this program activity at the local level (Long, 1979).

There were also many local I&R centers sponsored by special-interest groups and "Action-Line" programs sponsored through the newspapers, radio, and television, one of which was sponsored by Urban Coalition (Long, 1973).

The Veterans Information Centers, modeled after the British CAB's, were developed after World War II by the Retraining and Rehabilitation Administration of the Department of Labor. There were over three thousand centers, but most were closed by 1949 (Long, 1973).

Funds from the Community Health Services and Facilities Act of 1961 provided grants between 1962-67 to State agencies and other public or non-profit agencies for activities promoting the creation of new or improved ways of providing health services outside the hospital, especially for chronically ill or senior citizens (Long, 1973).

Although the Social Security Administration showed interest in I&R services and conducted studies regarding the extent and quality of service in some offices, their support was limited due to work loads. There was interest to re-evaluate the position of providing I&R services through social security offices in 1972 during the Nixon Administration (Long, 1973).

The Administration on Aging sponsored projects involved in I&R and research. This Administration under Title IV projects looked to define the scope and limitations of these services particularly as they applied to senior citizens. Other federal agencies also had interest in I&R services (Long, 1973).

Long (1973) points out that there had been much overlap and confusion due to the numerous I&R centers providing these services as well as agencies providing these services and not designating themselves as such. The services were provided mainly to the disabled, the chronically ill, and the aged. It was understood that other people needed help in gaining access to human services, but that access was often a problem. In a later paper, Long (1979) states that part of the reasons for duplication, fragmentation, and inadequate services was due to there being no clear conceptual model regarding I&R services. He feels that the model needs to clearly delineate between information-collection functions and the information-dissemination functions of an I&R program. Information-collection functions should be centralized, comprehensive, and continually updated. He feels that collecting, classifying, and organizing would be overwhelming tasks. He discusses the possibility of public libraries and those trained in information sciences to perform these tasks. This led to the discussion of assigning the overall responsibility to the Library of Congress where there are staff who are skilled in the analysis and classification of various government documents and could keep abreast of them. In turn, university and public libraries have access to these documents via the Library of Congress, as well as staff trained to read, comprehend, and classify them. There would need to be consultants from the human services disciplines, professionals and

organizations to the Library of Congress to develop a classification system for human services information and to relate to changes from laws and regulations.

The task of collating this information at a local level could be accomplished by the establishment of contracts with agencies within local communities to obtain and provide the information. Agencies would collect information in a standardized manner around a specific category of need or interest and send it to a centralized bank for integration obtained from other contractors throughout the country. The central national agency would be responsible for making information available in a variety of forms (Long, 1979).

Based on the findings of the Wisconsin Information Service (WIS), that people tended to use I&R centers closest to them, Long (1979) feels that the dissemination of information should come from different sources that are geographically close to potential users. If materials were inexpensive, perhaps small store-front type agencies could provide quality I&R to consumers.

Long (1979) then addresses the question of who would provide the service. Another finding from the WIS project indicated that the academic qualifications and formal human services training did not seem to play a relatively important role in the quality of I&R service provided. Therefore, Long (1979) states "to the extent that functions of information and referral can be separated into information gathering and information dissemination, it may be possible to bridge the gap during this transition period with specialists from library and information sciences for the former function, (with consultation and advice from the human services community) and with various human services personnel, including social workers, counselors, and trained volunteers in the

information dissemination function, (with consultation from information specialists on the most effective ways to store and retrieve information and to use the information products which are available through the centralized information-gathering agency)" (p.17).

There was a rapid growth of I&R programs in the 1970's with new free-standing I&R agencies and I&R units within existing health and social service agencies. There was an interest in providing more generic I&R services to serve broader population groups, and services for special groups such as the handicapped, unemployed, women, and children increased as well. It was a period of large-scale research projects sponsored by the Administration on Aging (AoA). The outcome revealed that age specific programs needed access to generic age-integrated I&R programs. An AoA Task Force promoted networking and in 1977 published an I&R Guide indicating baseline criteria for I&R service delivery and also held workshops to highlight advantages of networking. On the State level, availability of Title XX funds for I&R program development and training promoted rapid growth of I&R services during this period, providing I&R services for all and not just the poor and it increased the role of the State in the service. Settings expanded for I&R services as well beyond traditional social service agencies to libraries and work sites. By the end of the 1970's a U.S. General Accounting Office report recommended a task force to design a national policy and plan to advocate for federal I&R centers on a comprehensive level (Levinson, 1988a).

The movement into the 1980's was filled with cutbacks in funds, thereby creating the need to improve access to and coordination of existing services. This lent itself to promoting linkages for organizations. In the private sector there was corporate support

for I&R services for child care and increased employee benefits with I&R services in Employee Assistance programs. A new AoA Consortium with representatives from the public, voluntary, and private sectors emerged to "inform states and community agencies of the need for cooperative relationships necessary for the effective use of available resources and to promote the networking of I&R programs" (Levinson, 1988a, p. 29).

In the area of telephone usage, hotline services, as one form of an I&R program, promote networking since often in the course of seeking help for clients, the hotline depends upon obtaining information and referrals from other human service agencies (Levinson, 1988a).

I&R networks owe much of its major expansion to advanced technology in communications. Centralized data bases for access, storage, and retrieval aids in the handling of the volume of data. The potential for more effective and efficient delivery of human services through centralization of I&R services will enhance linkages within this field. Throughout the 1970's and 1980's I&R promotion was greatly expanded due to the efforts of the United Way of America and the National Alliance of Information and Referral Systems, Inc. (AIRS) (Levinson. 1988a).

Authors such as Zucker (1965) and Kahn (1966) appear to have been impressed by the British CAB system which was identified as a client service. It was perceived as a conceptual framework which could be utilized for client oriented services in the United States. Social service exchanges already existed in the United States, however the client was the agency. As the Social Service Exchanges declined, I&R services started to grow,

with the client being the individual. This required a transfer of model from one that represented agencies to one that represented individuals.

3. Models

Since interest in I&R systems developed in social work, many different types have been identified. Levinson (1988a) aptly states that it is helpful to study other models as they can provide useful guidelines when designing an I&R service.

Zucker (1965) feels the CAB came close to representing an ideal model. She states that the service must be available to all, must be developed from a local level, be flexible, independent, have volunteers and professionals. She advocates for the two professions of social work and law to work together in this area.

Levinson (1988a) states that the British give more recognition to the abilities of the CAB's to provide data for policy, planning, research, and social reform, and the role of the volunteer in providing direct service is critical in its operation. She further states that the United States needs to develop its own unique mode; that the organization of the CAB is different than here; that they have their own management committees, and are responsible to regional CAB area committees who are accountable to a central office of the National Association of Citizens Advice Bureaux (NACAB); that the CAB has a standardized resource file provided by the NACAB. I&R in the United States is not guided by national policy nor is it called upon to serve national purposes. The United States has many different informational systems.

At the core of a model presented by Long (1979) is a centralized resource bank where information is collected, collated and stored. Information is funneled to decentralized I&R centers where it is dispensed. There are particular advantages when a resource bank serves as a repository of information that is easily accessed by local centers. First, Long asserts, is cost saving. Each center is relieved of responsibility to organize, maintain and update information. Second, it frees the local agency to focus on direct service.

Different types of I&R systems identified by Levinson (1988a) include the following:

(1) "Informational I&R System" which responds to all inquirers whether by telephone, walk-in or mail;

(2) "Free-Standing I&R Agency System" where I&R is the only service provided and the service operates independently from another program or agency;

(3) "Interagency I&R Subsystem" is a unit operating within a host setting and connects clients to resources within and outside of the host or parent agency.

(4) "Intra-agency Subsystem" is a unit that connects clients to other units of the parent agency in which it is located;

(5) "Centralized Network" systems involve several I&R agencies in a service area that are accountable to a generic I&R agency. A central agency contracts with other agencies and is responsible for providing I&R services for them;

(6) "Decentralized Network" involves several I&R agencies in a service area that may or may not connect with other I&R agencies.

4. Functions

Kahn (1973) delineates essential functions of an I&R program as (1) recruit clients; (2) provide simple information about the agency; (3) advise on how to proceed, that is, suggest a course of action; (4) direct caller to agency or service; (5) provide support; (6) help caller with a telephone contact or letter of referral; (7) go beyond reported problem in helping people; (8) follow-up to ascertain if needs are met; (9) monitor whether information and/or referral was appropriate; (10) facilitate programs for those with common problems.

The functions of an I&R system should include: (1) to listen to a clients needs and concerns; (2) exercise patience in allowing the client to fully communicate their needs; (3) to identify the problem; (4) to obtain a resource; (5) to motivate a client to follow through with a referral; and, (6) to maintain records, organize and update resource files (Long, 1979).

While the basic functions of an I&R program are information, assistance, referral and follow-up, the means by which I&R services are provided is dependent upon factors such as the setting, structure, auspices and clients served. I&R can provide service by mail, walk-in and telephone or a combination thereof. No matter the technique, it is agreed that the availability of a range of services in one setting facilitates the search for information and provision of appropriate assistance (Levinson, 1988a).

To offer comprehensive services does not necessarily assure access. Kahn (1973) suggests that social workers are particularly suited to I&R as assuring access to services, spreading knowledge and creating linkages, identifying programs, and delivery of services.

All fall within the domain of general social work services. Essential components of access, he posits, are information, choice, referral, complaints, advocacy and legal services.

On an individual level, I&R aids the person requesting help with coping skills by providing information, referral, and psychological support. This support, particularly during a crisis, can help with physical and mental adjustment because general well-being is preserved through the reduction of isolation and stress. On a broader level, community networking enhances the public's awareness of programs, services, and benefits , as well as increasing community support (Simonson, 1987).

Each of the models includes some form of networking. Zucker (1965) proposes it between social work and law; Long (1979) and Levinson (1988a) to enhance decentralization; Kahn (1973) to share knowledge.

As noted earlier, networking with others such as community agencies is essential for services to enlarge the resource bank from which to obtain information and referral sources for the consumers. Some authors, including Kahn (1976), emphasize the importance of networking of agencies to provide more effective services to clients. Networking, however, is a difficult end to achieve because it involves time-consuming activity to continually identify and maintain contacts and to keep information current.

Community networking enhances the public's awareness of existent services and program and extends the "community support base" (Simonson, 1987). According to Levinson (1988a), networking involves interagency programs, task sharing and collaborative planning. She says it is cost-effective and service efficient, but, she cautions, effectiveness depends upon the competency of those involved.

I&R can be one of the crucial factors that promotes networking. Not only does I&R help provide information for the consumer; it also helps agency staff secure resource information for clients. Over the years, directories have been created, maintained, and updated as a source of services, and more recently, the computer has been introduced as another means to provide information and continual update. However, Austin (1980) emphasizes "the need for an overall plan for information and referral services, particularly in urban areas" (p. 38).

Populations served, functions, planning, and administrative issues need to be carefully defined and reviewed in order to integrate I&R services as a linking mechanism. The network arrangement needs to be flexible to accommodate changes in community needs and concerns as well as changes in state and federal laws. I&R will be the component that enhances communication for the community and agencies. Austin (1980) names three groups served: 1) the human service agencies; 2) other significant community personnel (doctors, lawyers, teachers , police, etc.); and 3) the general public. The general public would be well served if the human service agencies and community personnel were systematically organized and coordinated to relate to public needs at any given time. Furthermore, Austin (1980) promotes the following basic functions necessary in developing a community-wide I&R system: 1) provision of factual information to the above noted constituencies; 2) short-term counseling to clients in order to assess the problem, to identify the appropriate service, and to make an appropriate referral; 3) provide or have access to ancillary services to facilitate obtaining help; 4) producing

current files of those resources often used for help; and 5) collecting information regarding problems and requests, and systems problems in order to plan and evaluate.

Lastly, there are planning and administrative issues concerning the I&R concept, (single or multiple), sponsorship, scope of services, updating information, classification system, nature of service, and relation to development planning (Austin, 1980).

An excellent example of a network system on a national level, is the Citizen's Advice Bureau (CAB) located in England. Designed on a national level approximately 1000 local units are accountable to the national organization which sets standards and methods of operation. National CAB assumes responsibility for including a standardized resource file (Levinson, 1988a). Levinson (1988b) also describes an I&R service involving the networking of librarians, social workers, and older volunteers. Professional informational skills, human relation skills, and the background and capabilities of senior citizens combine to form this model, Senior Connections, as a means to enhance access to information and resources for the senior citizen population.

Another example is the Wisconsin Cancer Information Service (WCIS), which is a part of a national Cancer Information Service network funded by the National Cancer Institute (NCI). Meetings between representatives from WCIS offices countrywide and NCI project coordinators occur to discuss common issues and make decisions affecting all offices (Roston, 1980).

Linsk, Osterbusch, Simon-Rusinowitz, & Keigher (1988) support the notion that social work needs to network in the area of home care services in order to provide comprehensive services for senior citizens and their families. Family members traditionally

have been involved in varying degrees in caring for the elderly, and requests are made by these caregivers for services regarding counseling, information about care, and financial support.

Based upon the premise that networking can be mutually advantageous for all participants, four separate social work programs within one state university system became involved in an informal collaboration effort to deal with mutual concerns. Administrative, curriculum, personnel, and professional/personal issues were handled in this manner. The effort was seen as a source of information, advice, and help. Areas served included student transfer, recruitment, program development, and collegial relationships. The collaboration fostered professional growth and development as well as provided emotional support. Although there were differences regarding individual priorities as to the issues addressed, there was mutual agreement for the need for collaboration and commitment in terms of social work education (Brower et al., 1989).

As noted earlier, networking through the use of computer technology is a method of electronic communication that is presently being introduced into the human service profession. Telecomputing utilizes telephone lines to transmit information between computers. It is specifically designed to search and obtain information, permit conferences, and use electronic mail for communication within and among agencies. This method also has the potential to speed communication, (nationally and internationally), enhance information access, networking, case management, and promoting of services such as support groups (Finn, 1991).

Finn (1991) reports on a study of users of such a network, CUSSnet, (Computer Users in Social Services Network). They were located in schools of social work, a university based counseling center, a hospital, and in the home of a private consultant. Although several programs are no longer operating due to funding and manpower problems, the author is a strong advocate of this means of delivery and coordination of services and recommends promoting its survival.

In another effort to promote networking, Tovey, Savicki, & White (1990) state that since the computer is very much a part of our culture, it is incumbent upon nonprofit groups to embrace this technology in order to offer higher standards of service. Electronic mail was discussed as a means to share information, lower travel time and expenses, lower telephone expenses, equalize participation opportunities, reduce mailing expenses, permit quick response, and make better use of one's time as well as reduce the chance of communication errors. However, there are also technological, social, and economic factors to consider. Among these are: 1) the compatibility and installation of equipment; 2) the modification of the phone system; 3) the time, energy and cost of those involved in planning and maintenance; 4) the inherent impact on the social system and means of communication when changes are involved affecting work habits, interpersonal relationships, decision-making, and learning new skills (Tovey, Savicki, & White, 1990).

It appears that electronic networking is part of our future, but it will take time to involve individuals and agencies in becoming comfortable and familiar with this means of communication.

Survival of the network is dependent upon coordinated efforts to pool communal activities. However, agencies will respond to their own internal needs for survival. Agencies have different agendas and any differences regarding purposes must be negotiated and resolved in the interest of common goals. (Levinson, 1988a) proposes a model for I&R networks to; engage in policy formulation and planning; provide adequate resources for quality I&R services; recruit, train, retain competent professional I&R staff; maintain and update a reliable resource file; provide quality I&R relevant to the client population; and address organizational maintenance.

5. Standards of operation

As I&R programs proliferate, the need for standards must be continually addressed. Standards with more or less specificity have been developed over the years. However, there are neither official mandatory standards nor regulatory measures of enforcement. In her comprehensive report on I&R programs, Levinson (1988a) addresses the historical development of standards.

In 1967, early I&R standards were embodied in a Brandeis survey which served as a guide to future efforts to create such standards. The criteria required (1) that the service must be organized, (2) the service must be manned by at least one part-time staff person who is formally assigned to the service, (3) a resource file is to be maintained and (4) provision of I&R is to be the service's main responsibility. In 1973, the United Way of America published the first set of standards that emphasized criteria for quality I&R service (Levinson, 1988a).

The Administration on Aging in 1974 presented basic requirements for I&R service that included short and long range goals. Training for paid and volunteer staff was highlighted. When the Alliance of Information and Referrals Systems, (AIRS, Inc.,) published standards in 1975, they included a requirement for client advocacy. Otherwise, the standards were essentially an elaboration of those set forth by the United Way in 1973. In 1978, a second edition of the AIRS standards included policy, advocacy and planning. Outreach, though recognized as a component in the preface of the 1978 AIRS standards, was not included until 1983, when national standards were presented by the United Way of America and AIRS (Levinson, 1988a). In 1991, United Way of America published an edition with revisions that had been made in 1990 (United Way of America, 1991).

In 1978, the United States, the General Accounting Office surveyed selected I&R programs and evaluated them according to a set of minimum standards. The findings revealed that many I&R providers did not meet defined I&R standards. Inadequacies were found in resource files, follow-up, publicity and outreach. The results indicated high noncompliance, but a regulatory body was non-existent to enforce minimal standards for I&R practice (Levinson, 1988a).

Agencies have developed their own self-evaluation methods to monitor their services. The United Way developed an I&R Service Self -Evaluation Checklist and in 1982, a research-oriented, self-evaluation kit was created for use by Community Information Centers in Toronto (Levinson, 1988a).

In 1987, the Alliance of Information & Referral Systems published a self-evaluation manual that could establish a basis for accreditation (Levinson, 1988a).

The National Standards for Information and Referral Services offers one concise framework of minimum goal requirements; four categories encompassing twenty standards (United Way of America, 1991). This set of standards and operation criteria were developed and sponsored by United Way of America and the Alliance of Information and Referral Systems (AIRS) in cooperation with other national voluntary and federal governmental agencies.

Category I, Functions, represent tasks that should be performed by an I&R service. Included are a classification system, resource file, inquirer data collection, data analysis and reporting, training, promotion and access to service. The classification system should be standardized, based on standard service terminology to help obtain information, to make evaluation processes consistent and reliable and to promote comparisons of data on a national level. I&R services are expected to develop, maintain and use an accurate, current resource file containing information regarding community resources and presenting data on area service providers. A system of collecting and organizing data requested by inquirers should be created to meet individual and community needs. Means of collecting and organizing data would include statistics, data analysis and pertinent documentation regarding service use, client characteristics, unmet needs, gaps and duplications in services. Training should be provided for paid and volunteer staff. Community awareness of I&R services and objectives should be addressed through

activities designed and maintained by the I&R service. I&R services need to be easily accessible to individuals and the community (United Way of America, 1991).

Category II, Client Service Delivery Functions, denotes standards necessary to provide information, referral, follow-up, and advocacy/intervention. Information giving involves information regarding human services. The range of information provided may vary from limited data such as an agency's name, address and telephone number to further information about community service systems, agency policies and application processes. Referral giving is more complex, including assessment of needs, evaluation and identification of appropriate resources, location of alternative resources for those for whom services are unavailable, and assistance in connecting inquirers to services. Follow-up determines outcome of referrals and may indicate that further follow-up is needed. Advocacy or intervention is involved when the required services have not been adequately provided by the organization within the service delivery system. It is being noted that advocacy is a recent addition to these standards and was not part of the original standards during the course of the project (United Way of America, 1991).

Category III, Organizational Structure, specifies standards under which an I&R service operate: auspices, staff, volunteers, financing and facilities. The auspices should ensure that I&R goals are achieved. Competent, ethical and qualified staff should be sufficient in number for service policy implementation. Volunteers should be utilized to promote service delivery. Adequate finances should be available to ensure service and maintain the noted standards and criteria. Facilities should be provided by I&R services to permit operation (United Way of America, 1991).

Category IV, Cooperative Relationships, represents responsibilities of the I&R service to the I&R system. This includes cooperative program development, decision making, functional arrangements and administrative procedures. Cooperatively, each I&R service is directed to develop I&R service programs related to community needs, resources and activities of other I&R services as well as to promote and be involved in planning, policy implementation and funding source maintenance. In addition, to avoid duplication and to improve delivery of services, each I&R service should maintain formal and informal cooperative arrangements implemented from administrative procedures from each I&R service (United Way of America, 1991).

To be able to meet the standards set by the National Standards for Information & Referral Services, I&R services are expected to embody certain attributes. Levinson (1988a) considers the following attributes essential for acceptable I&R practice: (1) availability -- universally available to provide service it claims; (2) accessibility -- able to be easily reached, phone lines open, physical access acceptable, able to speak with I&R staff directly, access to files; (3) appropriateness -- meets the needs of population being served; atmosphere , friendly, furnishings acceptable to public; (4) adequacy -- meets demands of clientele; (5) accountability -- to community, Board of Directors, and staff; (6) assured confidentiality -- protects privacy and confidence of clients; (7) affordablility -- service without extraordinary expense for clients and agency; (8) acceptability -- all groups receptive to service; client or callers feel comfortable in setting; (9) adaptability -- service tuned to social needs and organizational changes, policy issues, administrative issues; (10) assessability -- program evaluation through outside sources or within; long

and short term benefits; social and fiscal costs respecting effectiveness and efficiency of service.

Therefore, it is important when designing an I&R service to meet certain basic standards and criteria in order to provide quality assistance and access of resources for individuals, organizations, and communities.

Volunteers

"To volunteer is to choose to act in recognition of a need, with an attitude of social responsibility and without concern for monetary profit, going beyond one's basic obligations" (Ellis & Noyes, 1990, p. 4).

1. Historical background

One of social work's basic principles of helping people to help themselves can be traced back to the Judeo-Christian sects of commitment to perform charitable acts. The concept of charitable giving can be traced back to the Talmud, the collection of Jewish law and traditions and the Decretun, a collection of papal and church decrees dating back to the 12th century (Herington, 1984).

Voluntarism is the historical heritage of social work in this country brought over from even older English antecedents. Volunteers were appointed to ensure that programs of the Elizabethan Poor Law of 1601 were carried out. The governing force for all activities was embodied in the Social Compact of 1620 which was supported by Puritan doctrines of assuming mutual responsibility or cooperative action for the common good.

There was a lack of organized charity during the colonial period. Although poverty was considered unproductive, a need for some charity was acknowledged. Helping out a relative, for example, was a form of charity, but if no one was available, the local authorities became involved. This method was not adequate and almshouses were established, as in Boston in 1662 and in Philadelphia in 1732. Since the poor received something for nothing they were not held in high regard. Work houses were seen as better, particularly for healthy males (Ellis & Noyes, 1990). Colonial human service groups can be dated back to the Scots Charitable Society in Boston in 1657 (Pumphrey, 1961), St. Andrews Society of Charleston, South Carolina in 1730 (Ellis & Noyes, 1990), and perhaps to an earlier mutual aid group in New Amsterdam (Guzzetta, 1984). There were also private citizens who bequeathed funds or property, even slaves, and those who assisted in obtaining sick benefits and burial expenses in the field of labor. As people saw that helping others resulted in benefiting the community, especially with private attempts being inadequate, people realized that the taxpayer should help those who were not able to help themselves. Ellis & Noyes (1990) note that this was the beginning of institutionalized social welfare.

Many fields such as medicine, education, recreation, transportation, communication, safety, civic work, politics, the military, and journalism all had their roots in volunteering. In the area of medical care, for example, anyone with medical knowledge was consulted by others. Organizing by doctors eventually evolved into the Medical Society of the State of New York in 1794 (Ellis & Noyes, 1990).

After the Revolutionary War citizens were involved with the responsibility of self-government. Areas such as welfare, education, and local issues still needed individual participation since the government was limited with how much it could handle. Volunteer groups, known as Societies grew and formed a major force in the area of social welfare (Ellis & Noyes, 1990).

Voluntarism served humanitarian purposes as well as increasing the strength of organized churches in America. During the first half of the 19th century other reasons promoted voluntarism. Women were able to perform activities beneficial to the social system. They also became aware of the existence of inequality within this system, which ultimately led to the feminist movement. Women's work in voluntarism served as a means to protect traditional social values while providing women a socially significant role beyond motherhood and spouse. However, some authorities claim that volunteer work by upper and middle-class women led to upper class dominance of voluntary organizations which fed their respective values and interests and, in turn, gave the upper class economic control (Reisch & Wenocur, 1984). These volunteers could afford to devote time and energy and interest to the cause of the less fortunate.

Abolition and problems between the North and South leading to the Civil War interfered with social progress. Poverty, crime, and disorder were problems as the result of growth of cities. This led to the evolution of relief associations. Men and women were noted for their volunteer efforts in the field and the home front (Ellis & Noyes, 1990).

1866-1899 was seen as a time of transition as the nation began to re-unite after the Civil War. Volunteers were involved in areas such as labor, education and civil rights. It

was a time of turbulence with the rebuilding of the South, the continued expansion West and the older cities of the North. There was political corruption as well as efforts to help those less fortunate (Ellis & Noyes, 1990).

After the Civil War and the advent of the industrial revolution, there was a shift in the focus of voluntarism from mutual aid and self-help to concern for others. This was due, in part, to the massive dislocations and disruptions of family life that arose. In addition, the growth of the upper class and the legalization of philanthropic trusts created new opportunities for volunteer activities. The growing significance of charitable foundations led to the need to pay workers to monitor the funds, which, in turn, brought about conflict between volunteers and paid staff. Paid agents began to refer to themselves as "professionals" and with it came the notion of a need for training. The concept of professionals and volunteers overlapped and became confused. The volunteer was seen as one motivated to help on a humanitarian level without compensation; paid agents were seen as charity bureaucrats. At the beginning of the 20th century, training expanded and paid agents came to be called professionals. In addition, volunteers were seen as "do-gooders"; those whose activities were nothing more than something useful for them to do (Guzzetta, 1984).

By the end of the 19th century settlement houses were founded based upon the work of the institutionalized churches who sought to contribute to the social movement and improve the lives of those less fortunate. The settlement houses were supported by funds managed by educated women and staffed by volunteers. Eventually this means of providing help was not adequate in terms of dispensing the funds. A more systematic

way was needed to organize philanthropic activity which led to the charity organization; the first American Charity Organization being established in Buffalo in 1877 (Ellis & Noyes, 1990). There were more that 150 COS established between 1877-1904. Many professionals and business persons were supportive of this type of organization, as it dealt with social problems without interfering with upper class privileges. COS was noted for its use of volunteers, (generally middle or upper class women), to form personal rapport with the poor and provide aid through their opinions and suggestions. COS credited volunteer work as important, unique, and superior to paid work (Reisch & Wenocur, 1984). Filing systems were maintained listing their dependent clients. Friendly visitors, mostly unpaid, were recruited and trained to investigate applications for help. Attempts at codifying investigative techniques and understanding the reasons for poverty, the profession of social work evolved from the role of the friendly visitor (Ellis & Noyes, 1990).

Professional training was deemed necessary to handle functions such as program development, fund raising, and supervision. This led to less use of volunteers by the COS and by 1917, the volunteers performed routine office work tasks which were defined and supervised by paid personnel. There may also have been a decline in volunteers due to women's interest in other areas such as the suffrage movement and temperance (Reisch & Wenocur, 1984). Other societies began to train their workers, which led toward professionalization. There were paid workers in addition to trained volunteers. With institutionalization and effective administration of social reform and vast sums of money, came the foundation where efficiency and accountability from charity was needed. The

forerunner of the United Way of America evolved from cooperative fund raising. To deal with social problems, voluntary organizations such as the Salvation Army and the Volunteers of America evolved. There was also the development of volunteer peace organizations (Ellis & Noyes, 1990).

The period between 1900-1919 reflected the Progressive movement which involved collaboration between reformers from urban lower and middle classes, occasional organized labor, and those from rural areas. Leaders tended to be from professions who focused on organization, cooperation, efficiency, and data gathering all for the human good. Progressives advocated for direct involvement in government and that organized individuals could effect change. They were concerned about all areas of American life. This led to changes in social welfare programs, with philanthropy, the creation of state and national organizations, and the professionalization of social workers taking the place of much of volunteerism. However, volunteerism still continued; agencies recruited volunteers to visit families and provide supportive contact by upper-class women. Women had more time for activities outside the home. National voluntary health organizations began, including the Association for the Prevention and Relief of Heart Disease of New York City in 1915. The advent of World War I designated the end of the Progressive Era. Americans volunteered in the military and at home (Ellis & Noyes, 1990).

There was a temporary increase in voluntarism during the first world war, but, it declined again in the 1920's. Some evidence suggests that there was an increase in professional social work usage. Problems encountered in the utilization of volunteers

included training, supervision, and the lack of clearly defined roles (Reisch & Wenocur, 1984).

Between World War I and II there were severe shifts in the economic and social arenas. Traditions were challenged while other advocated for prohibition. Women won the right to vote in 1920. People focused on making money, but by the mid 1920's there was inflation and severe unemployment which led up to the stock market crash of 1929 and the resultant depression. Although President Hoover saw volunteering as part of the American way, the citizens looked to the federal government for assistance (Ellis & Noyes, 1990).

There was an obvious need for personnel after the Depression during the 1930's; however, there still remained confusion as to the relationship between volunteers and social workers, particularly with the public welfare system and the move towards group work and family treatment. Due to staffing problems in the public arena, personnel standards were lowered in order to involve volunteers (Reisch & Wenocur, 1984).

During the New Deal under President Roosevelt, the government became involved in welfare programs to bring relief to help the country. Volunteer organizations continued to form, as well as voluntary health and social welfare agencies. Volunteers were active in fund-raising speaking, and organizing. By 1932, the problems of unemployment and poverty could not be handled by the private sector as advocated under President Hoover. Federal programs were developed. The professionally paid social worker was now considered more competent to provide service. Volunteers were only allowed to be involved as board members and fund-raisers. However, there were other fields in which

volunteers were involved. People were mobilized in volunteer efforts during World War II, for example, with business supporting public service announcements and people involved in civil defense activities. Even though there was dependence on federal government, there was still a need for volunteers (Ellis & Noyes, 1990).

Professionals became responsible for direct service functions, administration, and training, while volunteers in direct service handled generally clerical responsibilities in the 1950's. The social work profession, by the late 1950's, was focused more on the more affluent than the poor and with it, volunteer-professional role distinctions were accepted. However, there was a re-focus on poverty in the 1960's, which forced a re-evaluation of volunteer-professional relationships (Reisch & Wenocur, 1984).

Between 1946-1969 volunteers were involved in areas of major social change and the earlier social and civic programs. The mood of the country shifted away from government sponsored programs. The early 1950's reflected the fear of communism and the area of civil rights saw federal and court attention between 1948-1960. In 1946 the National Heart Association changed from only medical professional to a voluntary health organization with a lay membership, but volunteers were restricted to specific roles. In the 1950's voluntary agencies were noted for maintaining visible roles for volunteers with new ways to utilize them. In the late 1950's self-help groups evolved as an outcome of this. Volunteers in social work were again valued and represented all walks of life. The 1960's, under John F. Kennedy, was a time of idealism and unrest. Volunteer groups were involved in both sides of the issues whether it be for civil rights or war

demonstrations. Activities ranged from research to violence. Voluntary health agencies and organizations grew (Ellis & Noyes, 1990).

Between 1960 and 1980, the federal government's spending in the area of social welfare greatly increased, resulting in the growth of professionalization in social work. With the growth of social welfare programs came the acknowledgment of the need for more personnel. One of the outgrowths of this was to reconceptualize the roles of volunteers and professionals. The government promoted voluntarism, including establishment of volunteer programs such as Foster Grandparents and the Retired Senior Volunteer Program (RSVP) (Reisch & Wenocur, 1984).

The increase in voluntarism had an impact in the political and economic arenas. Effects identified were lower salaries for professional and non-professional social service workers, cutbacks in human services and the perpetuation of the stereotype of women whose time given is considered of no economic value (Reisch & Wenocur, 1984). This has contributed to the continuing discussion regarding the collaboration and integration of voluntarism within the social work profession.

Between 1970-1989 volunteering was measured statistically for the first time. Organizations became concerned about volunteer support and their leaders and volunteers were recognized as those who ought to receive recognition. Volunteers became widely visible in many areas. The Nixon administration stimulated volunteer forces. Six existing programs such as the Peace Corps, RSVP, and Foster Grandparents were brought together to form ACTION. Included also was the Office of Voluntary Action Liaison and the National Student Volunteer Program. Several federal department started volunteer

programs and also made positive statement about volunteers. Congress also mandated an independent sector agency; the National Center for Voluntary Action. Students were more involved in volunteering to integrate classroom theory with real life experience. Senior citizens were living longer and were more available became involved in volunteering. Self-interest was considered an acceptable motive for volunteering by the end of the 1970's (Ellis & Noyes, 1990).

In the early 1980's the term "transitional volunteer" was used to describe those who used volunteering to bridge a gap between life changes such as death, divorce, or re-entering the work force. President Reagan promoted voluntarism and volunteering to get people involved in government and solving community problems. He felt that the private sector could pick up the gaps due to budget cuts., however, volunteer basic expenses were not available to pick up these gaps (Ellis & Noyes, 1990).

The 1980's saw voluntarism and volunteering as legitimate areas for research and bills were introduced into both houses of Congress to encourage volunteerism. Most did not pass, but in 1988, a federal resolution passed in both Houses "that promoted volunteer involvement as legitimate work experience and urged local governments and private employees to take a job candidate's volunteering into account when offering employment" (Ellis & Noyes, 1990, p. 293). Problems of the 1980's such as hunger, homelessness, and drug abuse involved volunteer activity. Since 1981 volunteers have been active in the area of AIDS (Ellis & Noyes, 1990).

Schindler-Rainman (1984) predicts transitional and challenging times for volunteers and those working with volunteers in the 1980's and 1990's. Volunteers were

coming from all walks of life, age groups, socio-economic levels, and ethnic backgrounds. Schindler-Rainman suggests that volunteers serve as direct helpers, decision makers, connectors, monitors of programs and functions, workers in social action causes, and in fundraising, and research.

Volunteer man-power is seen as a major force in our culture as well as on the international scene. Schindler-Rainman (1984) suggests reasons for the growth in volunteer opportunities. First, as our population grows older and diverse cultures expand, there is a need for more and varied services as well as a range of people, especially older ones, available to volunteer. New ways are required to involve, train, and recruit volunteers, as well as integrate courses and field work practice for social work students to learn about working with older and new volunteer populations. Second, federal tax cuts and smaller budgets exist in a time when there still exists demands for quality service. To address this need, the author suggests the "mobilization of volunteer energy, exchanging and sharing of resources, merging of overlapping activities and services, finding new sources of funds, voluntary reduction of overhead costs, discovering new ways to deliver old services, and moving toward collaboration and interdependence of disparate systems, services and groups, utilizing the reciprocal and complementary resources available in more creative ways" (p. 228). Third, the area of resource development needs to improve volunteer work conditions, provide better experiences for the older volunteer and for the physically and/or mentally impaired. Fourth, changing values concerning appreciation of differences, short-term commitments, mobility, and confronting norms necessitate volunteer opportunities that are reflective of these changes. This involves more temporary

volunteer experiences and promoting the understanding of value and life-style differences. Fifth, the corporate world has become more involved in the volunteer arena. There is a need for non-profit organizations to develop relationships with the corporate world to become involved in non-profit agency activities and as possible sources for funds or grants. Sixth, there are expanding opportunities to increase service as technology advances. Increased utilization involves training people to learn about these new technologies. And last, there needs to be planning for the future and with it, planning for areas of volunteer service as volunteers are seen as social change agents, particularly in the areas of patient rights and quality of life.

In a keynote address during a conference concerning volunteerism, Allen (1986) notes three trends creating new opportunities for organizing volunteers: 1) Dealing with social issues starts from the bottom up; a grass roots approach; 2) Due to alienation, people are looking for mutual support through volunteering; and 3) More value is being attributed to unpaid work.

Ellis & Noyes (1990) describe the 1990's as a nation of volunteers, as volunteers are active in all arenas of life such as labor, employment, business, industry, communications, transportation, education, public safety, social action, human services, and health care. "Volunteers locate and catalogue community resources, staff telephone hot lines, and make appropriate referrals" (p. 322) in the human service field. In the health care field "volunteer members support research and public education on a particular health problem, volunteers also serve on boards and advisory committees, handle fund raising at all levels (including organizing and staff telethons), and sometimes serve as experimental

subjects. Volunteers in such organizations can also be involved in direct service to patients and their families" (p. 322).

Historical, political, social, and economic issues affect the trends of volunteering.

2. Composition

Haeuser and Schwartz (1984) discuss the issue of volunteers as non-paid labor and their impact on job security and salaried staff, while they state that volunteers need not be used to replace or decrease staff. A policy statement approved by the NASW's 1993 Delegate Assembly states that "although volunteers can play vital roles in the human services, they must not be perceived as viable substitutes for professional care (NASW, 1993, p. 263). Although volunteers are unpaid, Haeuser and Schwartz (1984) say that a good volunteer program is not necessarily inexpensive and needs a qualified paid professional to conduct it. They emphasize that in keeping with the NASW policy statement, roles and responsibilities are to be clearly defined. Volunteers should neither be considered cheap labor nor less valued because they are not paid.

Class variables are significant in determining who volunteers. Reisch & Wenocur (1984), looking at volunteers between 1960 and 1980, also note that volunteering was related to social class: the higher the class based upon occupation, income and education, the higher the rate of volunteer participation. Wuthnow (1991) concurs that, "voluntarism is, and has been from its inception, largely a feature of the middle class" (p.307). In contrast, Haeuser & Schwartz (1984), report that volunteers in the 1970's

were coming from lower income groups and groups of all ages, from teens to those preparing for retirement.

In Britain, CAB volunteers, selected by a committee, have been drawn from the pool of retired civil servants and middle-class housewives. The volunteers found their work to be a satisfying experience, their dedication and reliability assets to CAB's program (Kahn, 1966).

A Gallup Organization survey conducted for the Independent Sector, a national association of philanthropic and voluntary organizations, reveals that there were 80.0 million adults, (18 years old or older), in 1987 and 98.4 million adults doing volunteer work in 1989. There was a slight decline in those volunteering in 1991 to 94.2 million. It was estimated that the percentage of adults doing volunteer work was 54% in 1989, a rise from 45% in 1987, but a decline to 51% in 1991. These numbers were obtained from three surveys conducted in 1988, 1990, and in 1992. During each time there were different economic climates. The first was conducted during a growing economy, the second during a steady economy, and the third during an economic recession. The Independent Sector (1992) states that at least a decade of information needs to exist before volunteer behavior can be analyzed under the different conditions. "These findings show that individuals contribute more when the economy is healthy. These findings also suggest that if volunteer participation remains steady or increases and the economy improves, giving will measurably increase" (p. 262).

The reasons people volunteer vary widely. According to Katz (1970), the motivation to become a volunteer is a complicated phenomenon involving social,

ideological and personal factors. For example, volunteers may be seeking solutions to personal problems. In such cases, displacement of goals can occur. One study of volunteers at the Council House Mental Health Services in Pittsburgh indicates that volunteers who were self-oriented related better to volunteer work than those who were service-oriented. These volunteers were interested in the program because they had personal contact with someone who was mentally ill. The author concludes that participation is encouraged when one is seeking solutions to personal problems. He further states that once the volunteer is connected to the program, the individual is able to pass to a stage of altruism, in which the person obtains satisfaction from helping others and no longer seeks help for him/herself.

This dynamic has been observed in self-help organizations but has not received attention in studies involving middle and upper-class volunteers in the more traditional social agencies. Katz (1970) contends that people in search of solutions to personal problems should be considered a powerful source of volunteers.

Zane (1992) states that larger numbers of people are volunteering to work with the poor, sick, charities, and volunteer organizations. He further states that volunteers come from a range of age groups.

Volunteers may be filling gaps between jobs or in idle non-work hours. Volunteering may help raise self-esteem and offer fulfilling activity. In addition, volunteers seeking work that involves skills used in direct service may receive pertinent training leading to job changes (Haeuser & Schwartz, 1984).

Manser (1987) concurs with the above, stating that motivation is based upon personal needs and interests and can range from altruism to self-interest and often a combination of both.

The decision to volunteer involves two steps, according to Chambre (1987). First there needs to be an awareness of an organization's need for volunteers. Second, there needs to be a commitment, which involves a "trigger event"; something that takes a general wish into more concrete action.

A volunteer's success not only depends upon appropriate assignment and utilization but, importantly, on the quality of the preparation for assignment, the adequacy of supervision and competency of the supervisor. Limited time for supervision and inadequate training will hamper volunteer performance (Levinson, 1988a). Conroy (1986) states that volunteers experience stress from "poor administration of volunteer programs, insufficient support of volunteer, and absence of systematic procedures for terminating a volunteer" (p. 8). Goals need to be clearly stated as it could be stressful when volunteer goals do not complement agency goals. Volunteers need to feel capable of the performing the job responsibility which involves clear job descriptions and tasks. Volunteers need supervision, training, evaluations, and recognition. Chambre (1987) concurs, stating that underutilization of people's skills and abilities can affect the retention of volunteers. Burn out can occur, as well, due to underutilization and the unnecessary subordination to paid workers.

In reviewing volunteer programs in clinical and social treatment and prevention areas, Michener & Walzer (1970) emphasize the need for professional supervision. A

verbal contract specifies that the volunteer provides service and the professional provides professional guidance. Through supervision, the supervisor facilitates the volunteer in developing helping relationships. It is the supervisor's responsibility to protect the integrity of the volunteer to remain "client focused" and "task oriented." The authors advise that the supervisor guard against involvement in the volunteers' personal problems and ensure that a therapeutic relationship be avoided. Professional supervision can be a rewarding experience for supervisor and supervisee. As noted previously, volunteers frequently feel guilty if they fall short of meeting the expectations of clients, even when expectations are unrealistic. Supervisors can recognize this reaction and help establish boundaries and achievable goals for volunteers.

Training needs to include learning objectives, continuing education and support conferences. Teaching content should relate to a preexisting knowledge base. Positive outcomes have been achieved with such techniques as introductory lectures, group discussion and interaction for values clarification. Volunteers need to share and practice common skills, through active listening and responding exercises, simulated case presentations and role-playing with guided intervention techniques (Simonson, 1987).

Based on a 1979 study conducted by McCaslin in Texas "training programs reflect some significant variations, but the service needs perceived by trainees tended to be similar. Even for highly experienced staff, ongoing training courses in I&R expertise are essential to refine service delivery skills and maintain updated information on changes in policies, procedures, and relevant legislation. Training sessions usually deal with four major areas of knowledge and practice skills" (Levinson, 1988a, p.129). They are agency

services, practice skills, policy analysis, and evaluation and planning. Levinson indicates that knowledge of the community and its residents is imparted. She advises that agency paid staff receive in-service training to deal with all requests when volunteer staff are not available. It is generally accepted that participation of agency staff in the creation of a training program tends to enhance and enlist the support and cooperation of the staff.

3. Characteristics

According to Michener and Walzer (1970), volunteers augment the treatment process by expanding resources for clients and the entire community. Volunteers are able to identify gaps in service and possibly initiate programs. They are able to advocate on behalf of clients as they are neutral, concerned citizens. Volunteers may have previous connections with other community groups. The authors indicate that volunteers can form relationships perceived as safe by the clients. They seem less threatening than the professional because they may lack the power, authority or control of the professional. Presently, there are fewer homemakers available than formerly because women are entering the paid work force in greater number (Levinson, 1988a). Mergenbagen (1991) notes the biggest change in volunteers in the past twenty years is because of women working. As a result, nonprofit organizations find it more difficult to secure volunteers to work during daytime hours. In addition, she states that with the rise in the number of divorced and widowed individuals, as well as single parents, child care responsibilities may likely interfere in their ability to volunteer.

Retired senior citizens are a major source of volunteers. For example, Retired Senior Volunteer Program (RSVP) is a program that recruits senior citizens (Levinson, 1988b). Levinson finds that I&R service provided at local libraries appeals to older citizens. They are learning and serving others. She finds volunteers motivated, committed, helpful and caring in providing I&R. On the other hand, some authors report concerns lest "rescue fantasies" of some older volunteers lead to over involvement (Michener & Walzer, 1970).

Chambre (1987) completed an extensive secondary analysis of data from a major survey of older volunteers and from her own research discusses trends for the older volunteer. She describes this population as a growing leisure class due to a number of reasons. Many seniors have pensions, less responsibility to their family, they do not have to earn a living, and were either motivated or forced to retire from work. This is a also a growing population. In 1940, when social security checks were first distributed, people over 65 represented 7% of the population or 9 million, In 1983 there were 27.5 million older people or 11.7% of the population.. It is projected that by the year 2020 the older population will represent 17%. With earlier retirement and longer longevity, what people do with their time changes over the life cycle.

Chambre's (1987) analysis of data reveals that "stronger ties to work and family roles are associated with a greater tendency to be involved in volunteering" (p. 30). She does not find that volunteering is a substitute for loss of family and work roles when looking at those who were widowed, retired, and who had differences in retirement patterns. Increasing age and declining health affects older people's volunteer activity.

However, the factor of increasing age does not have impact until after age 77 when people are less likely to volunteer and health status no longer appears to be a factor. It is suggested that this may be due to older people being less involved in some social activities at this stage. Chambre also states that because of education, occupations, and incomes, older people vary in their involvement in volunteer activity. These occur at all ages and continue when they become older. Reasons cited are: 1) costs in volunteering in time and money; 2) experiences will vary - higher status volunteers will receive positions involving more interesting work and jobs with more prestige, such as policy setting. Retirement is not associated with an increase in volunteering. However, semi-retired people are more likely to volunteer. Socioeconomic variables, although taken into account, do not eliminate the relationships of older age and declining health as reasons for less volunteer participation.

Although gender is not significant to volunteering for older men and women, there are some gender differences when other factors such as employment, education, and marital status were reviewed. Older women are generally retired from work rather than being homemakers, (one in ten), as in the past. Chambre (1987) notes that this is significant when programs are designed for older volunteers. Differences in volunteer patterns between older men and women seem to have been reduced, particularly when comparing similar work situations and occupational levels. However, retired professional women tend to become involved in volunteer work more than their male counterparts.

Older volunteers are also more involved in a range of social and leisure activities compared to those who do not volunteer. Volunteering is part of an active life. This

represents ways in which people grow older. In general, volunteers are less affected by poorer health since they spend more time involved in a variety of activities (Chambre, 1987).

Although volunteering is not a predictor of life satisfaction, a strong relationship exists because it is one aspect of a higher activity level. Further research is needed to look at the nature of volunteer work that does or does not contribute to well-being. There is support that activity, life satisfaction, and perceived health, variables that affect volunteering, are features that are generally stable over time in one's life. This continuity theory is suggested as a means to understand older volunteers (Chambre, 1987).

Over the years, students have been another major source of volunteers. They need to experiment with new adult tasks and work roles in preparation for their future. College age volunteers can be idealistic and ready to confront current issues. They want to change dehumanizing attitudes of society (Michener & Walzer, 1970). To the extent that there is an interest in community service careers such as social work, nursing and teaching, volunteering offers opportunities to test that interest (Levinson, 1988a). While the enthusiasm of young people is an asset, too much enthusiasm could be problematic if goals are too high, and expectations are unrealistic (Michener & Walzer, 1970).

In terms of motivation, voluntarism is a path to upward social status for those who sit on boards of social agencies. It affords opportunity to meet influential people in the community and to meet prospective clients (Katz, 1970). In addition, Haeuser & Schwartz (1984) discuss that volunteering promotes personal growth and

self-actualization which may, in turn, prevent mental health problems resulting from inactivity such as alcoholism, depression, and child abuse.

Phillips (1984) states that the program's professional staff need to understand the motivations of what leads one to volunteer. She notes two major areas of motivation, the first being altruistic, that is having a concern for others and the second, self-interest, involves learning, self-actualization and higher status. Phillips emphasizes the importance of volunteers becoming aware of what to expect from the program and what is expected of them, inclusive of their obtaining insight of rewards and limitations. She points out that different motivations appear during various phases of the volunteer experience; that initial altruism may shift to self-interest or rewards versus costs.

The volunteer experience is also attractive to professionals. Many mental health professionals have volunteered in direct service; an example being P.A., Parents Anonymous. The volunteer experience is rewarding in that it permits professionals to be facilitators, helps prevent professional isolation, and fosters personal satisfaction (Pincus & Hermann-Keeling, 1984).

Zane (1992) also notes that young professionals have joined the ranks of those who volunteer as businesses have encouraged this type of activity. Former President Bush's "Thousands Points of Lights" campaign and the resultant publicity attracted volunteers. In addition, the recession also contributed to the numbers who volunteered as people were unemployed or people donated their time instead of money.

4. Selection and utilization

Agencies need a good selection process to facilitate selection of volunteers who are appropriately aware, sensitive and skilled. An agency should have volunteer orientation and management competency to provide a satisfactory work setting for volunteers (Ross, 1983).

The selection of volunteers involves interviewing, obtaining personal information, assessing skills, professional qualifications, education, areas of interest and experience that pertains to the program. A responsible volunteer will demonstrate suitability for participation, commitment to program and schedules (Simonson, 1987). In essential agreement, Michener & Walzer (1970) stipulate that basic guidelines for selection involve commitment, dependability and interpersonal skills.

Ross (1983) relates the pertinent issue of selection and availability of volunteers to supply and demand. This affects the relationship between volunteers and non-profit service providers. There is a competitive market for volunteers, and agencies have been vying for volunteers. Where there is a shortage of volunteers, standards may be forfeited To fill gaps, an agency may compromise its standards and settle for a volunteer who is inappropriate. This could also negatively effect the volunteers' performance and/or availability which, at best, is generally limited.

Ross (1983) points out that individual agencies do not have the capacity to canvas the volunteer market thoroughly on an on-going basis. When this is attempted, the balance of supply and demand is impaired and problems can occur. Centralized organization and programs, to foster a community's volunteer potential and resources,

result in a cost benefit to the service needs of the community. "Before a community can optimize its voluntary potential, it must be capable of providing universal access between all volunteers and all available work settings. This demands some highly developed centralized capabilities and will provide the essential opportunity factor in assuring the best utilization of resources" (p.47).

When needs increase and funding abates there is more dependence on volunteers. A good volunteer is in demand (Ross, 1983). Due to large turnover, it is necessary to recruit continually (Levinson, 1988b). In order to close gaps in service it requires a professional to develop the volunteer system (Michener & Walzer, 1970).

Regardless of the age of a volunteer, there is a risk of feeling hopeless if one does not feel helpful. These feelings can be transferred to the client. The professional needs to be able to anticipate the reactions of volunteers and help them identify and appreciate the smaller steps clients take which represent positive change. Considering the above, it is also incumbent upon those screening volunteers to obtain any information regarding volunteers' sensitive life areas. If one is seeking to gratify one's own needs, one may tend to promote one's own views of problems and solutions rather than the clients. A recruiter must ascertain if problems exist that could interfere in their work assignment and select or reject the applicant on that basis (Michener & Walzer, 1970).

When looking to recruit volunteers from specific age groups, issues need to be addressed. According to Chambre (1987), there has been no systematic study of the differences between older and younger volunteers concerning motives, needs, desires, or performance. However, when one anticipates working with older volunteers, one needs

to look at this population in terms of continuity theory and patterns of people's lives. There are those who volunteered during their lives and those that will volunteer later in life and the goal is to appeal to both groups to participate. If presented not only as a way to serve others, but to be an enjoyable way to spend time and learn new skills, could appeal to altruistic motives.

Although Chambre (1987) presents recruitment methods focusing on the older volunteer, they are applicable for all age groups. Publicizing through mass media may be effective in receiving a large response, particularly in locating people with limited volunteer experience. However, many people may not be qualified. Voluntary action centers are good places to contact and some are designed specifically to recruit and place older volunteers. Some older volunteers may be new to volunteering or they may have used these centers over the years. Direct solicitation or asking people to give their time is worthwhile. It identifies people who, once recruited and trained are more likely to continue, offer appropriate job skills, and promote their ability to adapt, as well as enjoy the work. Community people can be utilized to identify volunteers by inviting them to an informal meeting which would show the need for a person's services and relationships can grow doing the volunteer work. Volunteers are also able to identify and recruit other potential volunteers.

Use of volunteers is not without pitfalls, concerns and problems. Michener and Walzer (1970) suggest using volunteers to minimize fiscal and staff shortages, especially in the face of a growing demand for services. In these circumstances, fears of paid staff are realistic and must be addressed. Reisch and Wenocur (1984) indicate cutbacks in service

were not experienced severely in the 1960s-1980s because of the growth of the large unpaid volunteer labor force. However, associated with this was the lowering of professional and paraprofessional social work staff salaries. In addition to possible loss of income, social workers may feel threatened when voluntarism itself has become professionalized. This has happened mainly in the areas of volunteer administration.

Schwartz (1984) cites problems being underutilization, inappropriate involvement, lack of clearly defined roles, and myths that volunteers are a source of cheap labor, altruistic, do-gooders, have unlimited free time, do not want supervision, cannot be fired, and do not have skills.

According to Manser (1987), the largest barrier are the negative relationships between volunteers and professional; that is, the inability or unwillingness of paid professionals to accept volunteers as legitimate partners. This involves opinions that only specially trained individuals can provide help in the human service field, threats regarding job security, possible replacement by volunteers due to budget cuts, and lack of knowledge about volunteers' skills and abilities. Chambre (1987) similarly states the above and notes that there are few trained to work specifically with volunteers. A potential problem and question arises when working with older volunteers. Are the older volunteers more skilled than paid workers or do they just think they are when involved in jobs of their former occupation?

Haeuser & Schwartz (1984) discuss covert and overt, unconscious and conscious resistance of professionally paid staff as obstacles in the use of volunteers. This has to do

with misunderstandings and the lack of professional training that promotes the value of voluntarism.

The negative connotation of volunteers being middle and upper class do-gooders and that social workers have territorial concerns are suggested as reasons for resistance. As noted, volunteers represent different socio-economic groups and include newer groups such as men, teens and seniors. Volunteers come with skills. The authors suggest that social workers need to be non-judgmental towards the volunteers and provide volunteer work for the less powerful, the poor, and the consumer of services (Haeuser & Schwartz, 1984).

Haeuser & Schwartz (1984) describe various factors affecting volunteerism. More sophisticated technologies lead to fewer jobs, earlier retirement alternatives, more frequent job and career changes. Volunteering offers individuals rewarding activities to help fill gaps in their lives during transition or retirement. Expansion in employee assistance programs and other company programs will need more personnel which could include well trained volunteers.

Volunteer paraprofessionals have been increasingly utilized on multidisciplinary teams; appreciated for their neutral status and ability to form relationships with clients. The client is able to identify the volunteer as someone to trust and with whom he or she can feel safe because the volunteer does not have the perceived authority that the professional presents (Haeuser & Schwartz, 1984).

Haeuser & Schwartz (1984) indicate that as self-help programs, hot lines and advocacy programs proliferate, there is a need to utilize professionally screened, trained

and supervised volunteers. In fact, these services are often staffed by volunteers (Levinson, 1988a).

Orr (1984) states that volunteers should be advocates. "Advocacy is defined as intervention on behalf of a group of persons such as children, families, the elderly, etc. in relation to those services and institutions that impinge on their lives" (p. 129). Methods utilized include "planning and coordinating services, seeking changes in administrative procedures, lobbying for changes in existing legislation or the development of new laws, educating the public about existing services and needs or ensuring that various groups, e.g., the handicapped, children, obtain their legal rights" (p. 129-130). Advocates may be "board members of a voluntary agency, direct service volunteers, members of public advisory boards, members of service organizations, clients served by individual programs or individual citizens interested in helping others" (p. 130).

Volunteers are often a major staff component in I&R programs, especially in local I&R organizations such as church programs, hotlines, and senior citizen services. In addition, volunteers work for special interest groups and programs dealing with health areas such as heart disease, stroke, and cancer. I&R-related programs of national organizations such as the American Red Cross and the Volunteers of America are mainly staffed by volunteers (Levinson, 1988a). Experienced volunteers can also be utilized to help train new recruits (Levinson, 1988b).

As mentioned, several writers believe that social work education must address and promote the utilization of volunteers. Authors such as Lowy (19840), Haeuser & Schwartz (1984), Schwartz (1984), and Levinson (1988 a&b), to name a few, concur that

the understanding and utilization of volunteers should be a part of the course curriculum and field work experience as well as a commitment made by the schools of social work. NASW (1993) recently supported this as well in order to implement policies that promote working relationships and volunteer programs.

Kahn (1976) aptly states "volunteers belong in the endeavor in all communities on all levels, and the tie-in of access programs, planning, and advocacy is apparent" (p. 33).

5. Relationship to professionals

Reference is made in the literature to collaborative efforts of social workers and volunteers in a variety of settings. The British CABs are 85% - 90% staffed by volunteers; and, nearly thirty years ago, Kahn (1966) describes their excellent capacity to deliver services. While volunteers still have less status in the United States than in the United Kingdom, their special attributes are nonetheless recognized by some writers (Levinson, 1988a). Allen (1986) states that collaboration between volunteers and professionals needs to involve the sharing of power. Kahn (1966) writes that volunteers have a range of skills and experiences and they are able to provide creative solutions to problems outside the usual approach chosen by professionals. In a Policy Statement approved by the 1977 NASW Delegate Assembly, the National Association of Social Workers acknowledges that volunteers are an integral part of our human service system. There is a need for a policy to guide the social work profession in the utilization of volunteers in the areas of policy making, advocacy, administrative, and direct-service roles. Formulation of policy guidelines would enhance the ability to make volunteers

partners with professional social workers. It is suggested that professional training, including class and field work, would lead to achieving implementation of such policy. NASW's 1993 Delegate Assembly issue statement notes "the National Association of Social Workers (NASW) should continue to formulate policies to guide social work practice in the interactive roles of professionals and volunteers working together in policy making, advocacy, and direct service roles" (NASW, 1993, p. 263). Furthermore, "policy is also needed to guide professional practice in encouraging, activating, and administering volunteer programs in such a way as to make volunteers collaborators with - but not replacements for - professional social workers" (p. 263). Volunteers and professionals make their own special contributions in their own respective rights.

Public and private sectors have sought to provide benefits for volunteer activity such as tax allowances, specific types of insurance, and reimbursement for expenses such as meals, travel, and child care. During the early 1990's, under President Bush, the government sought to protect volunteers from unwarranted legal liability. This was intended to promote equal access to volunteer activity regardless of income, race or ethnicity, gender, age, or disability (NASW, 1993).

NASW is dedicated to supporting policies and standards that promote the utilization of volunteers in order to improve the area of human services. Local human service agencies are encouraged by NASW to promote; legislation that seeks to involve volunteers in publicly financed programs at all levels and legislation that gives a tax deduction for expenses incurred by volunteers when they are not reimbursed for costs such as meals, travel, and child care; reimbursement for the above stated expenses;

performance standards that permit a means to evaluate benefits to clients based upon volunteer input; programs via a large citizen participation; and insurance coverage for volunteers, as well as, legislation to protect them (NASW, 1977, 1993).

NASW's policy statement (1977, 1993) also addresses the following:

(1) Volunteer roles should be a part of the agency structure.

(2) Volunteers activities need to include direct service, policy making, and advocacy.

(3) Policy should include nondiscrimination.

(4) Policy needs to involve clear distinctions in roles and functions between volunteers and professionals as volunteers are not to take the place of qualified paid staff.

(5) Agencies need to have education and training programs for social workers regarding the utilization of volunteers.

(6) Agencies utilizing many volunteers should have a volunteers service coordinator position at the supervisory or management level.

(7) Employers and educational facilities should consider volunteer experience when evaluating a person for employment or school credits.

It is not unusual to find volunteers and professionals working in tandem in I&R programs concerned with specific diseases such as cancer, heart and stroke (Levinson, 1988a). Michener and Walzer (1970) point to the utilization of volunteers in clinical and social treatment programs and in the area of prevention. In the view of these authors, social work practice is enhanced by mutual efforts of social workers and volunteers. Volunteers tend to be familiar with informal and formal resources, and have knowledge

regarding norms and sociocultural characteristics of the local community (Levinson, 1988a).

Lowy (1984) states that barriers exist between professionals and volunteers when organizational structure is not clear. The situation is exacerbated when functions and roles, expectations and images remain unclear. Resistance of the professionally paid staff stems also from misunderstandings and a failure in professional training to teach the value of volunteers and to hone skills in how to use them (Haeuser and Schwartz, 1984). Further, staff may perceive volunteers as incompetent, and volunteers, themselves, often express concern about their own competence and performance. Thus, negative feelings may be experienced by staff and volunteers alike. Kahn (1966) expresses concern that volunteers may be incorporated into the system without enough time and expertise devoted to their training. Under these circumstances, role strains are inevitable. If the volunteer placement is inappropriate, volunteer satisfaction and performance diminish (Ross, 1983). Anxiety decreases with volunteer role definition and the realistic setting of goals (Michener & Walzer, 1970)

Malishchak (1982) states that given the scope of voluntarism, there is the task ahead of us to professionalize the nation's volunteers. Although, he states, that there may be differences in training volunteers versus paid professionals, there are similarities that should be observed by those who train volunteers, whether for a voluntary-based agency or for a voluntary project of a non-volunteer organization. He identifies four areas. First, needs analysis and instructional design involve determining the strengths and weaknesses of staff and designing a training model based upon them. He points out that, although

training programs specifically geared for the volunteers may be more costly and time consuming, ultimately, a more skilled volunteer team is more profitable. Second, volunteers need to feel worthwhile and a part of the team effort. This bonding helps promote loyalty especially during unstable times in an organization. Third, the volunteer experience needs to be challenging and stimulating by providing greater responsibilities such as coordinating, supervising and recruiting other volunteers, fundraising, and public relations activities. Lastly, there needs to be in-house staff training in order to implement the above.

Not all volunteers are capable of handling an I&R service. They need training and supervision on a continual basis to maintain the quality of service (Ross, 1983). Volunteers can advocate, locate available resources, and identify gaps. In the course of assessing needs and resources, volunteers stimulate community interest and engage in exchange of information with other groups and agencies. Levinson (1988a) states that the success of a volunteer is tied to adequate and competent supervision, that volunteer performance may be negatively affected by professional biases against the use of volunteers in I&R programs. Since the volunteer may appear as a threat to the professional's job security, the professional may be resistant to assign tasks to the volunteer that may be viewed as professional I&R tasks, and, in turn, adversely affect volunteer utilization and relationships with professionals.

Simonson (1987) describes a hospital program of social work collaboration with volunteers who are trained as peer counselors. Training is based on the premise that the quality of their education can determine volunteer functioning and retention. The

volunteers are taught specific concepts regarding care, such as principles of volunteer peer support and counseling and their relationship to social work, health care, hospitalization, home and placement, side effects of medical treatment, client coping styles, respect for confidentiality, knowledge of resource referrals and awareness of social casework skills. Volunteers then attend four additional hours of education on a yearly basis. Peer support meetings for case review occur every six weeks for two hours. These provide supervision and support for volunteers as well as opportunity for review and problem-solving. The original group of trained volunteers remained active and worked in the program for three to five years. Simonson finds that low turnover rate, enhances continuity, quality, and effectiveness of services are all dependent upon support provided to volunteers.

Kahn (1966) describes the training involved in the British CAB's. Early on, volunteers take an initial training course and have to be willing to engage in additional training. There is an emphasis on field observation and personal contact with service agencies. Presently, volunteers are in a mandatory training program that is monitored by the central office of the National Association of Citizens Advice Bureaux. The NACAB provides training materials and consultants to oversee quality assurance (Levinson, 1988a).

A library-based I&R service, Senior Connections is staffed by library and social work students and older volunteers under the guidance of library-staff I&R Coordinators. The social work interns are mainly responsible for volunteer supervision. In addition, the already trained volunteers help train new volunteers. Overall monitoring of the program

administration, supervision, and training is done by Senior connections staff, and faculty from the professional schools monitor student internships. Training involves teaching the necessary skills needed from meeting a client to the completion of the service. It is emphasized that it is of particular importance for the volunteer to learn when professional intervention is indicated. Training sessions also include information regarding concrete services such as Medicare, housing and transportation which is organized and overseen by I&R staff. I&R staff have also designed materials such as a "Volunteer Handbook"" and "Training Syllabus."" Videotapes obtained through a New York State Legislative grant and J.C. Penney Company grant also enhance the training program (Levinson, 1988b).

The American Heart Association published a document promoting the implementation of I&R services which includes the recruitment and training of volunteers (AHA, 1980).

6. Coordination, skills, and functions

Although the profession is not always identified, there is agreement in the literature on use of a professional to coordinate the I&R program. The role of the program coordinator in I&R can be quite broad, as summarized by selected authors.

Perlmutter (1984) states that "volunteer programs can be considered an appropriate setting for the practice of social administration by an administrator who is a professional social worker" (p. 117). She states that the administrator of volunteer programs have responsibilities including defining roles, interpreting functions, and bridging the gap between volunteers and professionals.

The social worker can act as secretary, trainer, director and coordinator according to Kahn (1966). He also notes that social workers are particularly suited to I&R for assuring access to services, spreading knowledge, creating linkages, and identifying programs and delivery of services (Kahn, 1973).

The program coordinator who oversees the program should be a professionally trained volunteer administrator, evaluator, manager, community educator and social worker. Responsibilities include program planning, development and direct supervision of volunteer activities (Simonson, 1987).

The program coordinator acts as a link between the community and program, and may be an active innovator of programs. The coordinator role involves initiating community contacts to recruit and preliminary screening of volunteers. The coordinator must be identified as the person to whom volunteers, staff and interested others can turn in order to obtain information regarding progress (Michener & Walzer, 1970).

Responsibilities include screening, recruitment, orientation, staff education, supervision of volunteers, volunteer training, workshops, recognition programs and identifying creative opportunities for volunteers. Since staff and volunteers interact, it is incumbent upon the coordinator to interpret to staff the value of volunteers and promote mutually supportive relationships (Michener & Walzer, 1970).

The coordinator connects the volunteers, staff, agency leader and clients from within the community. It is essential to know the roles and sustain functioning of the above: 1) for volunteers, to provide satisfaction and growth experience and meet individual needs; 2) for agency staff, to facilitate their use of volunteers in productive,

non-threatening, creative ways that are distinct from professional duties, tasks and responsibilities and, to develop detailed job description for volunteers and professionals in the I&R service; 3) for Board and agency executives, to teach the role of the volunteer and the difference between professionals and volunteers; 4) for clients, to ensure that they are getting quality service from professionals and volunteers; 5) for community, to solicit contributions and enlist support for the program's service (Haeuser & Schwartz, 1984).

The coordinator needs skill in administration, recruitment, counseling, program development and supervision in order to plan, organize and manage the program as well as screen, place and supervise volunteers on an ongoing basis. Awareness of political, economic, and social factors that affect service delivery is essential. There is also the need for public relations skills and the ability to perform constant reevaluation of the I&R service.

According to Epstein & Tripodi (1977), the coordinator should provide oversight of and engage in specific activities, as follows:

(1) Select, train, and supervise staff

(2) Design patterns of staff organization and deployment

(3) Modify and revise program.

(4) Manage fiscal activities such as accounting and auditing procedures.

(5) Report to the agency regarding operations and progress.

(6) Submit periodic budget requests to the agency.

> Many see I&R as a professionally administered service, with direct services delivered by nonprofessionals and volunteers. Well-trained professionals are needed for activities such as supervision, consultation and program development. Additionally, they should have organizational skills that promote interdisciplinary partnership, thus reducing professional competition and aiding in complementary relations. Unfortunately, professionals can interfere with this collaboration when each profession adheres to its own methods of accomplishing activities (Levinson, 1988a).

Regardless of training and background, all I&R service providers must have "knowledge of community resources, skills in linking clients to appropriate resources, maintaining confidentiality and accountability to an official body as well as to the general public." (Levinson, 1988a, p. 128)

Lowy (1984) summarizes job qualifications for professionals:

(1) Appreciation of the competence and learning levels of the volunteers.

(2) Skills to assess competence and assign tasks appropriately for the benefit of the client, volunteers and professionals.

(3) Skills in recruiting, training, orienting, monitoring and evaluating contributions of the volunteers.

(4) Abilities in defining contributions, tasks, limitations of the volunteers, re-assigning when indicated, relating their work to those of professionals.

(5) Ability to share with volunteers the value of their work.

As noted previously the literature supports the need for social work students to receive training in volunteer administration (Haeuser & Schwartz, 1984; Schwartz, 1984; Herington, 1984; Perlmutter, 1984).

According to the AHA guide, the I&R service would be handled by those trained in social work methods (American Heart Association, 1980).

To prepare the social worker for programs involving volunteers, Lowy (1984) states that any training for social workers should cover specific objectives for work with volunteers, understanding teamwork and cooperation, analysis of tasks to be done by volunteers and professionals; additionally, training should be directed toward acquisition of skill in recruitment and selection of volunteers; preparation, planning and implementation of a volunteer program; ways to help volunteers maximize competency, interests and abilities; and continuing education for professionals and volunteers.

The program coordinator would be able to oversee the project, optimize volunteer activities, train volunteers, interface with the committee, administration, and office personnel, as well as evaluate and modify the service.

In terms of overseeing the volunteer component, the volunteer administrator as a profession has evolved as a professional field during the latter part of the 20th century. There exists a body of research and knowledge regarding volunteer management as a recognized profession. Numerous national organizations and volunteer bureaus have grown over the years; they bring together and support directors of volunteers. The role of the volunteer administrator has expanded to include a variety of ways to meet needs. The administrator can become involved in a community resource person, as well as, one who oversees labor relations. He or she needs to be able to differentiate between legitimate issues versus underlying sources of resistance of the paid staff towards the volunteers. They especially need to avoid exploitation of volunteers due to funding problems, nor use them as a short term solution to problems caused by budget cuts (Chambre, 1987).

Chambre (1987) discusses that there are no academic degree programs for this position. Some schools offer certificate programs or a specialization in volunteer management. Therefore, many perform this role with various credentials and academic backgrounds. Directors need skills when working with volunteers and have expertise in the specific discipline for which they coordinate the volunteers.

Telephone services

There is considerable literature on utilizing the telephone in a variety of ways and settings.

Initially, the telephone was used in the area of prevention, particularly in the area of crisis intervention. In 1953, a religious organization in London, the Samaritans, established suicide prevention as their main function. Assistance was provided by volunteers, the telephone their tool. Twenty years later, the Samaritans had expanded to become an international organization with 17,000 volunteers and approximately 150 branches (Hornblow, 1986).

In the United States, three telephone crisis intervention services began in 1958, one a suicide prevention center in Los Angeles. This was followed by other hotlines (Grumet, 1979). There were approximately 500 telephone crisis centers by 1972. As their names imply, the "hotline" services cover a wide range of functions and serve diverse subgroups in the population from "Youthline", to "Parentline," "Rape Crisis", "VD "Hotline," "Family Network" and "Gayline," etc. (Hornblow, 1986).

Levinson (1988a) notes that pre-recorded telephone informational services, in the area of health, expanded greatly during the 1970's. An example is the Wisconsin Cancer Information Service, a specialized telephone I&R service to deal with cancer related porblems (Roston, 1980). Another example from the health field is Tel-Med, The "Healthline" (1992), a service provided by Lenox Hill Hospital in New York City. By using touch-tone telephones, callers can receive answers to everyday health questions twenty-four hours a day. A telephone information service offered by the American Heart Association is "Heartline," a free telephone library of tapes covering a variety of cardiovascular and health subjects (New York Magazine, 1989).

Hornblow (1986) states that "the growth of telephone counseling services is perhaps symbolic of many characteristics of the community mental health movement. These include a challenge to institution oriented care, a move away from patterns of accountability dependent on a professional hierarchy, an affirmation of caring resources within the community at large, and a recognition of the need to provide support and intervention as close as possible to a point of personal crisis" (p. 23). He concludes that there has not been convincing evidence that, at the level of primary intervention, the telephone counseling services have reduced the incidence of psychological disorder. These studies suggest telephone counseling is helpful in supporting those with chronic disease and disability. They indicate that telephone services can be useful in providing information on health care and in facilitating access to care.

Besides using the telephone for crisis intervention and as outreach to the disabled, the literature discusses the use of the telephone as a therapeutic device. Rosenbaum

(1977) discusses the continuation of psychotherapy by telephone and/or correspondence for selected patients who move to a distant state. Ranan & Blodgett (1983) present the use of the telephone as a possible solution to the problem of engaging an 'unreachable' or resistant client. A group of New York certified social workers has advertised their alternative to traditional therapy: help by telephone in addition to face-to-face counseling (Tel-A-Counselor, 1990). In The New York Times, Fanning (1991) discusses the pros and cons of providing therapy for business executives over the telephone. An article by Gill (1989) in New York Magazine describes a therapist providing long-distance therapy over the telephone. Some psychologists object to the offer of providing therapy over the telephone, deeming it "dangerous" and "unethical". They believe that a therapist misses the non-verbal cues and general appearance of the client. However, those offering telephone counseling services say they offer "real help" to those who otherwise would be unable to afford it, or fear seeing a therapist (Buie, 1989). Sheppard (1987) discusses the use of the telephone as the primary modality to provide on-going therapy for those who would not have engaged in this process; pointing out that one does not receive the full potential of help which may occur with face-to-face contact. Hiratsuka (1993) describes the trend toward using "900" numbers and how some social workers have responded to this as a possible trend and variation in treatment. However, there is concern about regulatory issues, quality control, accountability, and potential abuse by uninformed or those addicted to the telephone. In this connection, Miller (1973) states that individuals vary in their affinity with the telephone and both patients and therapists vary in their

facility in its particular use. His data suggest that therapists need to be cognizant of their own reactions to telephone usage.

In Miller's (1973) view, the "telephone medium" has five properties: spatial, temporal, single channeled, mechanical and dyadic.

The "spatial" property refers to the actual space between two people who communicate. Anyone who has access to a phone may enter the therapist's office. Even as the phone allows action at a distance, the speaker seems extremely close to the listener which creates an unusual kind of intimacy.

The "temporal" property relates to the fact that the patient has access to the therapist beyond the hours of a formal office appointment.

"Single channeled" is associated to the fact that the channel of communication is auditory. Lack of eye contact precludes observation of non-verbal cues that lend themselves toward visual fantasy. Communication is almost exclusively verbal and tends to be sequential and more logical than that which occurs in face-to-face contact.

The "mechanical" property refers to the phone as a concrete impersonal object. "It does not require the same kind of sensitivity involved during direct personal contact. Similarly, it does not tune in to the recipient's state and so may be extremely intrusive or 'insensitive' when the call is coming in" (Miller, 1973, p. 17).

Last is the "dyadic" property, typically, two people interacting with one another. The telephone thus has potential to reinforce "two person" communication and problem solving.

Kahn (1976) states that the telephone has major potential as a means to provide access for services such as information, referral and follow-up. The more vulnerable populations such as the sick, elderly, and poor, often have difficulty obtaining services. The ultimate goals of agencies is to meet human needs, but often barriers exist (Levinson, 1988a). An I&R service provided over the telephone would provide accessibility for clients.

Proponents of telephone counseling conclude that, with appropriate staffing and supervision, I&R programs can broaden their practices beyond information and referral alone, to more therapeutic interventions.

Levinson (1988a) states that I&R service systems operate through a variety of media, including telephone services, radio, and televison. She further states that "the major means for communication in I&R services is the telephone" (p. 77).

The telephone is also a means by which to conduct surveys. The advantages and disadvantages in the use of the telephone to conduct surveys is discussed by Dillman (1978). Disadvantages include difficulty in obtaining detailed information, respondents being uncooperative to unknown interviewers, and respondents not having control of the interview. Advantages include cost and time effectiveness. In addition, respondents should be prepared to expect a telephone contact which increases response rate. Norms for telephone contact reduce the likelihood of a respondent terminating a contact once the commitment to respond is made. Speaking to the respondent with a respectful attitude and in a personalized manner enhances the exchange. Trust is often built in the agency affiliation of the interviewer.

Howard, Meade, Booth, & Whall (1988) discuss the success of a telephone survey designed to obtain data regarding a particular health problem. They attribute their success to advance verbal informed consent for the telephone interview, printed materials to standardize the interview, scheduling the interview at a convenient time for the respondent, thereby providing some control over the interview, and allowing respondents to discuss their feelings and problems. The researchers felt that the respondents were rewarded by their contribution to help a worthy cause. Yegidis & Weinbach (1991) concur with these advantages described in the use of the telephone and note that this method avoids the presence of the researcher and possible interference in the process.

III. PROJECT DESIGN

Need

The AHA published the Heart Information Service Program Guide which discusses "steps in organizing and conducting an effective program" (AHA, 1980, p. 1). It encompasses principles regarding the operation and methods to be used as well as sample materials and policy statements. In addition, the AHA guide states that the Heart Information Service is "a basic and continuing obligation of every Heart Association" (AHA, 1980, p.1). The AHA acknowledges that the guide should be used as such and adapted to the individual needs of Heart Association programs.

According to the AHA Program Guide (1980) applicable at the time of the project, a committee approach to program development was favored. The committee was expected to comprise various disciplines and areas of expertise, sharing a common base of knowledge about heart programs, community resources, and patient and family needs. In addition, the guide suggested involvement by social workers in I&R, asserting that such program should be "best handled" (p. 5) by people trained in social work. Provision of information was described as "a basic and continuing obligation" (p. 1) of member programs.

As noted in the Introduction , the AHA, Nassau Region agreed to the development of an Information and Referral (I&R) system as a pilot project which, if successful, might be used as a model for future development. Theodore Webb (1989), Executive Director of the AHA, Nassau Region indicated that no such program existed in New York State.

For the purpose of reviewing and monitoring the development and operation of the Telephone Information and Referral Service, (I&R service), the Psychosocial Committee agreed to regularly scheduled monthly meetings.

Major aspects in the planning and design phase included funding questions, availability of staff, resources, scheduling and contingency coverage of the I&R Service, response of professional staffing, and evaluation and follow-up issues.

Selection of a design model had to consider agency mission and public relations policies; specific service function, nature of information to be disseminated; and internal operations coordination.

The design had to provide for a specific, specialized service within a formal agency structure. It had to be consistent with agency policies and mission. The agency expected the service to project a positive service image to the community, increasing agency visibility and, it was hoped, community support of all kinds. Agency proposals to use the service for a specific fund-raising activity was rejected by the committee as a threat to the integrity of the service.

The design had to address particular service needs which were informational, but not therapeutic. Expectations of service providers were for them to be fully informed regarding stroke and heart disease, to be empathic and helpful, but to provide no therapeutic opinions, judgments, or treatments. The information was to be professional, not personal; to be warm and friendly, but not reflecting personal experience and opinions.

The service had to provide specific information and educational material dealing with heart and stroke and their relations to heart and stroke patients and/or their families.

Experience had shown that callers frequently sought information related to matters such as heart attack and stroke information and symptoms; cholesterol, diet, and exercise information; heart and stroke clubs for patients and families; stress management; cardiac rehabilitation programs; and availability of counseling.

The service had to provide information and referral in a systematic, routine manner to replace the random, unsupervised, inconsistent dissemination that it was intended to replace. This required a single, central organizational format. Formerly, calls for information received responses from whomever answered the telephone. The caller might have talked to a professional, an administrator, or the receptionist. The service had to provide for coordinated internal operation for I&R provision.

Review of identified models indicated that a modified form of Levinson's (1988a) "Informational I&R System" could provide the basic framework. However, this Levinson model provided for walk-in and mail as well as telephone response. Since the focus of the project was the telephone response, the walk-in and mail response aspects were discarded, at least initially. Because the service was expected to link "clientele to resources within and outside of the host agency in which it is located" (Levinson, 1988a, p.79), and to serve the mission of the AHA, the design also included aspects of Levinson's "Inter-agency Subsystem" and "Intra-agency Subsystem" models, respectively. This integrated model seemed most feasible for addressing the needs and service mission of the AHA, Nassau Region, and the national organization's guidelines.

As previously noted, telephone utilization is a major factor in the realm of prevention and in providing a variety of services in the areas of mental health, chronic

disease and disability, and basic health information. Although not intended for crisis intervention, the I&R service makes use of the telephone, and on occasion, a call could be critical in nature. As noted by Hornblow (1986) telephone services can be useful in providing information on health care. In fact, "handling telephone inquiries is a vital function of the AHA. It affords the opportunity to analyze inquiries for the purpose of relating program planning to needs expressed by heart and stroke patients and their families " (AHA, 1980, p. 3). In addition, it provides individuals and families with ready access for I&R as well as ventilating with another concerned person at the other end of the telephone. The initial call is "often the only contact a person has with the AHA and it is important that the individual receives the kind of information and service that will leave a positive image of the AHA's program" (p. v). Furthermore, the AHA already has a telephone library of tapes discussing heart and stroke health related topics. Use of the telephone enables those who are unable to travel distances or for whom such travel is inconvenient; or who are homebound, whether due to psychological or physical reasons, to have low cost access to an extensive array of assistance and information. Self-help systems have also made use of the telephone as in Parents Anonymous, noted earlier (Pincus & Hermann-Keeling, 1984, p.108).

The use of the telephone was believed to lend itself to the design of the project which needed an easily accessible, low cost, non-threatening means of communication for those who desired information and resources regarding cardiovascular disease and related health issues. The AHA, Nassau Region specifically supported the telephone as the primary means of operating the needed I&R service.

The literature provides a wealth of material supporting the utilization and training of volunteers in the provision of I&R services. Zucker (1965), Kahn (1966), and Levinson (1988 a,b), among other authors, address the use of volunteers in a variety of capacities including the staffing of the I&R service and in helping to train newer volunteers. The British CAB is an excellent and well-established model to draw upon in integrating a volunteer component into the project. The British model serves as a means to provide I&R service. Levinson's (1988b) library-based I&R service is also a well-established model utilizing the volunteer services of the senior citizen population.

The AHA's program guide specifically states that "the principle that the varied activities making up Heart Information Service are guided and carried out by volunteers, working in cooperation with staff" (AHA, 1980, p.1). In addition, in a June, 1986 AHA Statement of Purpose states "a network of committed volunteers is critical to our success" (p. 2) in order to achieve AHA's long-range goals.

The AHA program guide did not specify the details in training volunteers, however, it states that a Heart Information Service Committee would be responsible to "define responsibility of staff and volunteers to the Service and the Committee" (AHA, 1980, p. 33). The guide states that the service would most likely be handled most appropriately by volunteer or staff trained in social work counseling technique. The literature also supports the use of a professional to manage the entire program, often citing a social worker as an appropriately trained professional.

In April, 1990, (during the course of the project), the AHA published a manual, Telephone tips, techniques and model responses for answering inquiries to the American

Heart Association. The guide outlines basic telephone techniques and AHA policies. Areas covered include skills regarding listening and handling complaints, responses, sample questions and answers.

Components

1. Organizational structure

Designing and planning the program focused on aspects of service referred to in the literature. Assuring universal access to services as noted by Long (1973), Kahn (1973), and Levinson (1988) was considered a priority. Specifics in the area of I&R involved reviewing models, (Zucker, 1965; Long, 1979; Levinson, 1988), functions, (Kahn, 1973; Long, 1979), networking, (Zucker, 1965; Kahn, 1973, 1976; Long, 1979; Levinson, 1988; Simonson, 1987; Austin, 1980; Brower, 1989; Finn, 1991; Tovey, Savicki, & White, 1990), and standards, (United Way of America 1983, 1991). Utilization of the telephone in terms of the means to provide service was reviewed, (Hornblow, 1986; Miller, 1973; Buie, 1989).

Volunteers were also a necessary entity of focus in the design of the project as discussed widely in the literature review. Aspects considered in planning use of volunteers were utilization (Levinson, 1988a,b; Ross, 1983), characteristics (Michener & Walzer, 1970; Mergenbagen, 1991), motivation (Pincus & Hermann-Keeling, 1984; Michener & Walzer, 1970; Philipps, 1984), training and supervision (Simonson, 1987; Michener & Walzer, 1970; Conroy, 1987; Levinson, 1988a,b), and problems (Levinson, 1988a; Schwartz, 1984; Lowy, 1984; Manser, 1987; Conroy, 1987).

Tools with which to evaluate and monitor were created.

The planning and design of the project took nine months. Every step involved collaboration with the Psychosocial Committee members and the Executive Director. The Psychosocial Committee, which normally met on a monthly basis, included the I&R project as an agenda item every month. Sanction of the proposed I&R program was solicited through (1) meetings of the Psychosocial Committee to discuss plans; (2) meetings of the Psychosocial Committee and the I&R sub-committee with the Executive Director to obtain authorization to proceed with planning the I&R service; (3) meeting with American Heart Association staff to present the service proposal and to solicit their opinions and concerns regarding the re-establishment of the I&R program.

The Executive Director was not only receptive, but enthusiastic about the project. He favored an I&R project making clear these requirements or which met these conditions 1) that it would not be a financial burden; 2) that no paid staff would be expected to respond to I&R calls; 3) that continuing recruitment and training of volunteers be an integral part of the I&R program; and, 4) that requests for services other than I&R would be referred to other appropriate agencies. The Executive Director observed that despite the American Heart Association's endorsement of an I&R service, there were no such programs in the State. He expressed conviction that the project could develop as a model I&R service to be replicated statewide.

The final program design did not follow one specific model, but drew upon selected features, modified to fit the specific goals of this project. Based upon a review of the models, the design incorporated certain features which corresponded to Levinson's

(1988a) "Informational I&R System", whereby response is provided to all inquirers whether by telephone, walk-in, or mail. For example, the design used Levinson's "Intra-agency Subsystem" type model to relate the local agency project to regional and national agency goals and guidelines. The "Inter-agency Subsystem" type model provides for the service to refer to outside agencies. In the sense that heart and stroke information is published by the national AHA and made available to the local regional AHA's, there is a centralized resource bank where information is collected and organized, an aspect of the design drawn from Long's (1979) model. The plan called for the service to respond to all I&R inquiries, mostly by telephone. To assure consistency in analysis, no walk-in or mail responses were considered. Most information would be obtained from the national office publications. This would also be a cost savings and allow the focus to be on service provision.

Essential functions of an I&R service were considered and based upon those presented by Kahn (1973), Long (1979), and (Levinson, 1988a). It was a priority to provide heart and stroke I&R in one location in order that callers would not need to search further. Recruiting of clients would be accomplished through news releases written by the program coordinator and approved by the Psychosocial Committee and Executive Director; and advertisements in the AHA, Nassau Region's newsletter which is published several times a year. Information, referral, follow-up, ability to listen to callers' needs, identification of problems, facilitation of communication, motivation of callers to follow-through and maintenance, organization, and updating of records would be handled by the volunteers, who would be trained and supervised by the program coordinator.

In establishing project boundaries, psychotherapy was specifically excluded as inappropriate and beyond the scope of the project. Whether or not to offer psychotherapy was an issue that needed clarification during the project planning period. The Executive Director supported the program coordinator's position that I&R should be provided in a caring, empathic manner, but psychotherapy services were beyond the scope of this project. This corresponded to the national AHA's description of an I&R service that required there be more depth to the service than solely the provision of information; that is, that service include listening, expression of concern, and other more personal or intimate kinds of response than mere distribution of data. A policy issue related to referral was the possibility of a referral being deemed unsatisfactory by the caller. While acknowledging the client's right to accept or reject the information and/or referral offered, the problem was to avoid endorsement of any particular individual or agency. To address this problem, it was decided that a minimum of three referrals would be provided in cases in which referrals were appropriate.

It was generally assumed, based upon past performance, that the receptionist would not direct calls to the volunteers but would attempt to answer caller's questions. In order to avoid this possible undermining of the program, the receptionist was informed and involved respecting the planning of the program and the manner in which it would operate. This assured understanding and cooperation. When the receptionist was replaced, during the term of the project, the replacement was fully informed of the project and the role of her position in it. Additional concern related to cost and the agency's willingness to underwrite minimal necessities like a telephone, office space, materials,

copy machine, support staff for typing, equipment such as a desk, phone, and file cabinet. Availability of a conference room for meetings and training sessions had to be assured. Costs were projected as thoroughly as possible, even including for refreshments for monthly meetings of volunteers, and a annual holiday party. Funding was solicited from the Executive Director, who approved the expenditures. Volunteer availability was also a concern, so planning included on-going recruitment and replacement. In addition, since the program coordinator was not on site, (except for one morning per week and for monthly meetings and training sessions), staff would be available to provide assistance to the volunteers.

As determined by Kahn (1973), Long (1979), Levinson (1988), and Simonson (1987), networking with other community agencies was considered essential in terms of recruiting volunteers, as well as obtaining information and referral sources, and in turn, in providing more effective service to callers. The program coordinator was given the task to contact other agencies in order to recruit volunteers and, as the project progressed, to urge the volunteers to communicate with other agencies to maintain and update the resource file, and inform others of the existence of the I&R program.

In the designing and planning of the I&R project, National Standards for I&R Services were consulted and incorporated. As discussed elsewhere, the National Standards comprise a list of twenty. Most were included directly, but all appeared in one or another from. For example, standards directly included in planning included "information", "referral", "follow-up", and "volunteers". Included indirectly were

standards such as "auspices", "classification", and "decision-making" (United Way of America, 1983, 1991).

Past experience prepared the AHA, Nassau Region to expect to receive most inquiries for I&R over the telephone. The telephone has widely been utilized in the area of prevention as, for example, with hotline services (Grumet, 1979; Hornblow, 1986), informational services (Healthline, 1992; Heartline, 1989; Hornblow, 1986), and as therapeutic means to help resistant or unreachable clients (Rosenbaum, 1977; Ranan & Blodgett, 1983; Miller, 1973; Buie, 1989). Given the extensive precedents for telephone use and the history of the agency experience, it was decided that the telephone would be the primary means of communication for I&R, follow-up and resource information. It was decided that the service would also respond to the occasional walk-in and mail inquiries, but that these would not be considered in analysis of project outcomes.

As noted, there was consensus in the literature supportive of the use of a professional to coordinate the I&R program. The program coordinator role was designed as one that would oversee the entire project and deal with administration, recruitment, program development, supervision, staff and community linkages. The program coordinator was a professional social worker, as well as were other members of the Psychosocial Committee. Another member, a social worker, was assigned as a consultant to the program coordinator.

Organizational structure was clarified, professional training planned, evaluation of volunteer skills and appropriate placement of volunteers was developed, awareness of staff

reaction and possible subjective reaction of the program coordinator in regards to the volunteers also was considered in planning.

Resources were not available to recruit paid staff. Agency experience with volunteers was positive and provided a precedent which led to the decision to utilize volunteers to staff the service. The literature was widely supportive of their use, and discussed possible resistance of staff whether because of threats of job security, vagueness in responsibilities or unacceptance as legitimate partners (Manser, 1987; Conroy, 1987; Levinson, 1988a; Haeuser & Schwartz, 1984; Pincus & Hermann-Keeling, 1984; Schindler-Rainman, 1984; Reisch & Wenocur, 1984). Therefore, the program coordinator anticipated possible tension among personnel. There was concern that the staff might not be friendly or helpful to the volunteers. To deal with this possibility, project personnel were informed about recruitment, selection, training, and informed of on-going supervision. Recruitment involved contacting agencies that help place volunteers; preparing news releases for local papers; developing advertising for the AHA newsletter, and polling the office staff for any leads. Planning for selection involved assessing the volunteer's characteristics, capabilities, skills, interests, reasons, or motivations for volunteering. A form was designed (Appendix A) to include date, name, address, telephone number, birth date, education, work experience, other relevant information, and availability for volunteering. Training and supervision were considered a priority in order to maintain standards of operation, delineating responsibilities, and evaluating performance, and specific training program were planned.

Before recruiting any volunteers, the training sessions were outlined. Content was divided into three segments. Session I: Presentation of an overview of the program and its objectives, policies, and procedures of the American Heart Association organization affecting the types of I&R to be disseminated. Discussion of definition, delivery of service, resources, resource file, documentation of data, types and examples of requests for information and services, and procedures for building the resource file. Session II: Instruction in interviewing techniques and interventions, problem delineation, referrals, follow-up, and advocacy. Session III: Review of follow-up procedures, role playing, and an introduction to the operation of the office, i.e.; telephone use, literature and file location, introduction to office personnel.

Due to volunteer turnover, there was ongoing recruitment and three sets of training session were offered during the course of the project. Planning of monitoring and evaluation included training sessions, and supervision, scheduling meetings and designing necessary forms/data sheets. The program coordinator responsibilities were set, including the review of minutes from the Psychosocial Committee meetings which reflected monthly I&R service reports. Scheduling plans included including the task list for the program coordinator, attendance at monthly meetings with the volunteers, recording minutes of these meetings, and reviewing intake and follow-up forms completed by the volunteers on a weekly basis. This was intended to afford a means to constantly monitor the project and report back regularly to the Psychosocial Committee. It also allowed the program coordinator and volunteers to communicate with each other between the monthly meetings. The purpose planned for the meetings with the volunteers

was to continue to build on skills, review data obtained on the forms, review AHA policy issues concerning the handling of requests for I&R, answer questions, and build positive working relationships among the volunteers and between the volunteers and program coordinator.

2. Program monitoring

The object of program monitoring is to evaluate whether the program accomplishes its stated purposes. Monitoring involves oversight of the program and permits examination of implementation after goals, population and method have been identified, and after the staff is recruited and trained. It enables the administrator to make decisions about the program specifically in terms of staffing, costs, training, policy and quality of operations and it provides a basis for making modifications and adaptations (Epstein & Tripodi, 1977).

Forms utilized for program monitoring allow comparison of data for:

(1) Identifying target population

(2) Identifying service standards

(3) Designing forms to record information

(4) Collecting and analyzing information

(5) Comparing actual performance and program expectancies (Epstein & Tripodi, 1977).

Program evaluation assesses effectiveness and efficiency. This involves collection, analysis and explanation of data. Effectiveness considers outcomes or the extent to which

the program does what it is supposed to do as stipulated in its stated goals. Efficiency considers "costs" relating to time management, money, materials and human resources in terms of achieving the program's goals. "Program efficiency is the ratio of program effectiveness to program efforts. This concept makes possible the evaluation of the relative costs of different program strategies to achieve the same goals" (Epstein & Tripodi, 1977, p. 111).

A formative evaluation method may be used to allow program decisions and improvements to be made during the program operation (Bloom, 1971). It examines significant steps in the project progress, such as data collection and analysis and preliminary applications. This helps prevent long-term costly mistakes and provides more immediate feedback (Epstein & Tripodi, 1977). Velesquez, Kuechler, & White (1986) support the use of formative evaluations in the human service field. In terms of program accountability, there has been a shift from an emphasis on methodological rigor to concern for relevance and practicability. The model they utilize focuses on program and client outcomes and utility of results to the decision makers as the main criteria. Formative evaluations lend themselves to program adjustments while undergoing periodic examination.

External validity involves the degree to which the data are generalizable beyond those subjects in a study; which is not often with a questionnaire, which allows subjects to tell the researcher what he or she wishes them to know (Epstein & Tripodi, 1977). However, formative evaluations are affected by internal validity, in that "program interventions do affect particular outcomes, evaluation instruments do accurately describe

and measure interventions and outcomes, and the evaluation process itself does not influence program outcomes" (p. 117). Internal validity refers to "looking over each item and assessing the degree to which it [fulfills] its intended role" (Reber, 1985, p. 810). It also controls effects of measurement and instrumentation by standardization of information gathering for respondents and helps by reducing time spans between the program stages for which data is obtained. Factors to consider are the occurrence of events that could not be anticipated and which could affect the intervention, subject change or maturation, situational changes, subject mortality, or any combination of factors that could be wrongly assumed to be due to the effects of the program's interventions (Epstein & Tripodi, 1977). During the course of the project, there was concern for internal validity in monitoring that the data being collected was representative of what information was being sought. By using the same kind of form and procedure in each case, internal validity was sought. Because there was a substantial amount of subjective material obtained, there was not the same degree of rigor as is expected in experimental research. Data were evaluated at each three month interval for the first year, as well as at the end of the project.

The former tenuousness of the I&R program in the American Heart Association office in Nassau County gave emphasis to the importance of being able to document any achievements of this project. The program coordinator, as a member of the Psychosocial Committee, attended monthly committee meetings, provided written and verbal updates, and evaluated the progress of the project. During the first year, a written evaluation was submitted to the committee every three months. All intake and follow-up forms

completed at the time of each review were analyzed by the program coordinator by evaluating the data from each question on the forms. The outcomes were presented to the committee. In addition, communication with the Executive Director was maintained to provide updates. The committee members also provided consultation and feedback to the program coordinator regarding any program issues. Concerns encompassed volunteer recruitment, response to callers, adhering to American Heart Association policy and gaps in service.

The program coordinator reviewed all intake and follow-up forms on a weekly basis. Direct contact was made or memos were left for volunteers regarding problems, questions, or additional follow-up requests. Conversely, volunteers contacted the program coordinator or office staff whenever assistance was needed.

The program coordinator and volunteers met monthly to discuss general issues or problems and review specific intake requests. Ongoing discussions focused upon American Heart Association policies and their impact upon the given caller.

Based upon the formative evaluation design, on-going decisions and modifications were made during the course of the project to enhance service delivery. The priority was to be concerned with assessing and improving this particular program.

The summative evaluation may be used to measure results of a program intervention after it has been completed (Epstein & Tripodi, 1977). Bloom (1971) considers post-completion judgment of effectiveness to be "the essential characteristic of summative evaluation" (p. 117). The summative design allows for application of findings to other sites and to note generalizabilty of findings (Epstein & Tripodi, 1977). A

summative evaluation design was utilized at the end of the project. Data evaluated at that time were taken from intake and follow-up forms, as well as notes from meetings with volunteers. Data were collected from the intake and follow-up forms from October, 1989 through March, 1991. During that time there were 672 intake calls; 149 of those had a follow-up.

Special research forms were created during this planning phase. Authors such as Epstein & Tripodi (1977), Reber (1985), and Bloom (1971) provided guidelines regarding questionnaire formulation. More recent authors, Yegidis & Weinbach (1991), have supported this which provided legitimation for the approach used even after the completion of the project. Questionnaires are commonly used to gather data and to obtain facts and opinions from respondents. In the area of program evaluation, questionnaires are used to obtain a subjective evaluation of a social program (Epstein and Tripodi, 1977). Yegidis & Weinbach (1991) discussed the advantages of utilizing structured questionnaires. Subjects are able to respond to the same questions which are worded in the same way. It also provides the perception of anonymity since subjects generally realize that their responses will not be attributed to them because the data is worked within aggregate form. When responses can be anticipated by the researcher and the researcher wants the respondent to consider certain answers, closed questions are utilized. Closed questions provide simple processing and if the categories are inadequate, one can lose very important information (Epstein & Tripodi, 1977).

Open-ended questions provide a range of responses and the researcher can obtain more qualitative material and more depth into a topic. However, respondents can spend

more time answering questions and it is more time consuming and difficult to analyze the data due to a wide variation of responses (Yegidis & Weinbach, 1991). Open-ended questions are also good because less knowledge is required about the kinds of responses that may be obtained and it would not be easy to predict the responses (Epstein & Tripodi, 1977). A mix of open-ended and closed questions were selected. Two forms were developed. One was the intake form, "Request for Information or Service" and the other was the "Follow-up" form, (Appendices B & C). They were designed, following Epstein and Tripodi's suggestion to follow a logical order, to obtain desired information in its most economical form, and to collect data in a short amount of time. One wishes to receive a good response and reliable information in order to analyze and make informed decision-making. Respondents need to be clear about why the information is desired, why they are being asked to participate, and how the information will be utilized. If people feel that they will not be hurt and the information is being put to good use, they are more likely to respond. Issues regarding content needed to be addressed, such as wording and clarity. Contingency questions were also included which avoided asking questions which were not applicable, reflected efficiency of administration, and helped organize the information collected. Length of questionnaire was also considered and certain information was not sought, such as certain demographics (Yegidis & Weinbach, 1991).

Based upon the writings of Dillman (1978), Howard, Meade, Booth, & Whall (1988), and Yegides & Weinbach (1991), the decision was made to have volunteers administer the intake form and the follow-up form over the telephone as a way to obtain information to be used to monitor and evaluate the program. Although face-to-face

collection of data may be preferable in order to obtain a high completion rate, it was not a realistic approach due to time constraints and man-power. Mailing was an option, but there were substantial costs to consider, as well as the possibility of low return rate and uncertainty as to who actually completed the forms. It was decided to be more aggressive in terms of response rate and the telephone was utilized as the means of administration.

Plans were made to have one intake form completed for each call. The purpose planned for the intake form was to obtain relevant data about the person for whom the caller was seeking information. This included the name of the caller and the name of the person or the relationship of this person to the caller. It specified date of the call and return call in order to demonstrate the timeliness of the response by the I&R staff. It identified the age of the person needing service, thus facilitating the selection of appropriate material and information.

A telephone number was obtained to enable the volunteer to provide additional information at a later date and to permit follow-up. The community of residence was obtained to indicate the geographic areas served. A specific address was not to be requested by I&R staff unless literature was being mailed to the caller.

The impetus for the call, specifying the reason for the request was to be noted. In circumstances in which a physician contact was necessary, it was to be ascertained if the concerned party had a physician and whether permission to contact was forthcoming. The information and/or referral provided by project staff was recorded. In addition, callers were to be asked what prompted them to call the American Heart Association office. Permission to follow-up in order to assess the effectiveness of the service was to be

sought. Callers were to ask when a call-back would be convenient. In an effort to elicit the volunteer's reactions, they were asked to comment on problems and questions about the request. The program coordinator could address these issues during on-going monitoring or at monthly meetings. A place was provided on the form for the volunteer's signature.

The follow-up form was designed to determine if the service reached the intended recipient and whether it was done in a timely way. Questions were included to address whether or not the caller followed up with the referral, and if so, and what was the outcome. In the absence of follow through, questions were to be directed to identify what prevented the individual from doing so, including problems incurred in trying. This questionnaire was designed to obtain additional information about the caller's experience, such as, whether or not he or she had contacted another person or agency not referred by the I&R service and if so, what was the nature of the help received; if the caller was helped by American Heart Association's service, what type of help was received and what was most helpful; if the caller was dissatisfied, what type of help was expected. In an effort to rate the help received, some questions focused on caller satisfaction: 1) whether the I&R service provided accurate information and, at the same time, responded to the caller's request and 2) if the volunteer presented as concerned, warm, friendly, empathic and helpful. Response ratings selected were: "poor", "average", "good", and "excellent". If additional assistance was needed it was to be noted and provided at the time of the follow-up. The caller was to be asked if he or she would recommend the service to others and if not, he or she would be queried as to how the service could be improved. A

provision was made for the volunteers to note any concerns, problems or comments that would be addressed by the program coordinator. Last, the volunteer's signature was required. It was planned that a different volunteer from the one who handled the call originally would do the follow-up.

IV. PROJECT IMPLEMENTATION

Administrative functions

The program coordinator met with the Psychosocial Committee on a monthly basis throughout the planning and design phase, as well as, throughout the life of the project. A sub-committee, consisting of two members of the Psychosocial Committee and the program coordinator, was created to facilitate the planning and implementation of the project. Meetings with the Executive Director occurred several times on an as needed basis, for example, to discuss the extent in which the paid AHA staff would or would not be involved with the I&R service. Periodically, the Executive Director attended the Psychosocial Meetings in order to provide input during all phases of the project. Shortly before the project's implementation, the program coordinator met with the paid AHA staff to describe the I&R service, including the volunteer component and to receive input from them. Their primary concerns were volunteer reliability and expertise to man the service. It was explained that a schedule of coverage would be maintained and the volunteers would receive formal training and continued supervision and monitoring. The program coordinator also met alone with the two receptionists during the life of the project to explain the nature of the program, the types of calls anticipated, and the need to take messages for the volunteers when the service was not covered. The schedule of coverage would be given to her on a monthly basis and volunteers would contact her in the morning if he or she was to be absent.

The outcome of the above noted meetings resulted in several outcomes. The program coordinator presented monthly updates at each Psychosocial Committee meeting

regarding all aspects of the I&R service. Discussions focused on AHA policy issues and their effect on the provision of service, progress regarding volunteer recruitment, training, and supervision, types of inquiries and problems, and utilization of the intake and follow-up forms that were designed for the purpose of obtaining data and completed by the volunteers. A member of the Psychosocial Committee, who was also a social worker, was assigned to provide additional consultation to the program coordinator on an as needed basis.

Office space was obtained for the service and soundproof enclosures were erected to ensure confidentiality. Conference rooms were available for monthly meetings. Necessary equipment such as a desk, chairs, telephone, file cabinet space, and office supplies were provided. The service was granted secretarial assistance to type lists of resources, memos, letters, news releases, (Appendix D), schedules, and reports. A budget of ten dollars per month for refreshments at monthly meetings with the volunteers and fifty dollars per year for the annual volunteer holiday party was made available.

Press releases advertising the need for volunteers to staff an I&R service were put in the AHA, Nassau Region newsletter and in local newspapers. The program coordinator queried the office staff as to whether or not anyone knew of an interested volunteer. Agencies that specialize in supplying volunteers such as the Department of Senior Citizen Affairs and the Nassau County Office of Volunteer Services were contacted by the program coordinator. Those interested in volunteering contacted the program coordinator or names were referred to the program coordinator by the agencies supplying the volunteers. The program coordinator made telephone contact with these individuals,

described the service in more depth, and scheduled interviews. Prospective volunteers were interviewed. Volunteers completed the "Volunteer Information" form that requests identifying information, education, work experience, availability, and other information relevant to volunteering. During the interview, the program coordinator assessed whether or not the prospective volunteer appeared suited for this type of work, and, in turn, the volunteer decided if this was an appropriate place to volunteer. Telephone contact was maintained by the program coordinator before the training began in order to sustain the volunteer's interest.

Part-time coverage was provided during business hours (9:00 a.m. to 5:00 p.m.) During monthly meetings, scheduling of volunteers took place. If a volunteer was going to be absent, he or she would contact the AHA, Nassau Region office early in the morning to inform the receptionist that the service would not to be covered. The receptionist took messages and advised callers when to anticipate a return call. Coverage was limited to three mornings per week, consistent with the number of available volunteers. As noted earlier the schedule was left with the receptionist and a copy was on the volunteer's desk. A list with the volunteers' names and telephone numbers was also maintained and updated, as well as the program coordinator's name and number. The volunteer would sign in with the receptionist when he or she would arrive at the office.

The program coordinator reviewed all intake and follow-up forms completed by the volunteers every week during the course of the project. Volunteers left notes and/or questions for the program coordinator to review. Responses were provided for the

volunteers. Specific questions and general issues were noted by the program coordinator to discuss during monthly meetings with the volunteers.

Since the program coordinator was not on-site other than the times indicated above, the volunteers had the following recourse: the program coordinator was available by telephone to respond to questions. Office staff, particularly the Program Director, the office manager, and the Executive Director responded to questions and/or concerns posed by the volunteers.

Once the volunteers were trained, the AHA, Nassau Region publicized the service through news releases in local papers and by placing an announcement in the AHA, Nassau Region's newsletter.

Monthly meetings with the volunteers included responding to the volume of calls, questions, concerns, and/or feedback about the service, providing an arena to review or introduce AHA policy, reviewing any issues that related to interventive techniques, skills, and completing the intake and follow-up forms. Actual calls were used to provide examples or illustrate areas to be reviewed. These provided one of the ways in which to supervise the volunteers and oversee the program. Ideas proposed by the volunteers to enhance the program's operation were discussed. Some ideas were implemented and others needed to be directed to the Psychosocial Committee for review.

The program coordinator was responsible for the following activities: preparation of all necessary forms; organization of AHA resource material, including literature; organization of literature into categories for I&R use; continued maintenance and updating; organization and classification of resource file to provide cross references for

volunteer use; posting of upcoming events such as health fairs, cholesterol screenings, and lectures; attendance at monthly meetings of Psychosocial Committee; monthly meetings with volunteers, and periodic meetings with the Executive Director; periodic meetings with the consultant of Psychosocial Committee; meeting with paid AHA, Nassau Region staff for orientation to start-up of program; presentation of data analysis summary every three months to Psychosocial Committee; issuance of news releases advertising the I&R service and recruiting volunteers; ongoing contact with agencies who supplied volunteers; and interviewing, recruiting, training, and supervising the volunteers on a continuous basis.

Training

Three training sessions were scheduled before the operation of the service began. As noted earlier, the training sessions were divided into three segments. In the course of actual training, the program coordinator emphasized that information, referral and follow-up are the basic components of an I&R service. Requests would come primarily by telephone. However, there would be occasional walk-ins and requests by mail.

Volunteers were taught the following: 1) information assistance is an interactional process that focus on the consumer as the information seeker in need of help or assistance from the service provider; 2) the nature of the request ranges from simple inquiries to more complex matters dealing with personal problems. More specifically, referrals require that sufficient information be provided to the inquirer to enable him or her to follow through independently. What may initially appear to be a simple request may turn out to

be a highly complex one. When information is not readily available, further research is required. The level of assistance needed and availability may not correspond with how much will be accepted. Therefore, the volunteer's attention was called to the fact that a caller may appear to agree to a referral, but, in fact, experience difficulty in accepting it.

On the other side, volunteers had to be aware that information could only be given within the context of American Heart Association policy. Part of the training was directed specifically at completing intake and follow-up forms. Explanations and rationale for each item were discussed. The point was made that data are gathered only after the caller has been given the information requested. A complete address is obtained only if literature is being sent or there is an indication that other information will be mailed. Permission is obtained for follow-up. The reason for the follow-up is explained to the caller and willingness of the caller to receive a follow-up call is ascertained. Volunteers are advised that the AHA, Nassau Region is interested in the outcome of the referral, the effectiveness of the service and whether those assisted are helped. Volunteers were informed of the expectation that they specify their questions, concerns, reactions, etc. in the comment section and these would be addressed immediately or in monthly meetings.

In preparation for each session, the program coordinator secured conference room space, provided refreshments, and provided notepads and pens in order for the volunteers to take notes. Each session ran for two hours.

Each session provided detailed information and the project, the agency and its personnel, and tasks involved in the volunteer experience of this project. A description of the content and procedures follows:

Session I: Introductions were made by volunteers including background, (work and/or volunteer experiences) and reasons/motivations for volunteering. The program coordinator also described her background, (professional, educational, and relevant experience), motivations for project involvement, and conceptualized the program and purpose of the study. This overview included reviewing AHA policies and procedures that would affect the provision of service, defining I&R delivery of services, resources, resource files, documentation of data, types and examples of I&R requests. This was done in an effort to begin to foster positive working relationships among the volunteers and between the volunteers and the program coordinator. Identifying common bonds and interests would build commitment. It was especially intended to give a clear description of the program, goals, and objectives.

The volunteers presented their concerns about being volunteers in a host setting and questioned if their presence threatened the jobs of the paid employees. The program coordinator acknowledged their legitimate concerns. Although one could not definitively state that all staff would be responsive to them and the program, it was explained that since volunteers have worked cooperatively with staff in this office for many years; that the AHA is a major supporter of utilizing volunteers, and it was assumed that their presence would not pose a problem. If any problems were to arise, the program coordinator should be advised immediately. It was also emphasized that the volunteers were providing an additional service for the office, therefore, their presence should not pose any threat to paid staff. The staff were to be relieved of handling work that they did

not have the time or the training to handle and it was anticipated that once the program was underway, the staff would experience relief.

The volunteers were concerned about caller resistance to accept help and/or referrals. They were also concerned about whether or not they would be qualified to respond to caller requests immediately. These were important concerns and the program coordinator addressed these issues. The volunteers needed to learn over a period of time about interventive techniques and theory about working in the human service field. The program coordinator discussed these areas knowing that there would need to be continued discussions throughout the project.

The volunteers needed much help and teaching in the areas of client resistance and expectations regarding themselves and others. This was particularly true in helping the volunteers in telling the caller that he or she did not have the information needed, but would research it and get back to the caller. The volunteers were assured that the program coordinator was available to discuss problems as they occurred and during monthly meetings.

AHA literature was distributed to the volunteers to help familiarize them with the type of information disseminated by the AHA.

The next date for the training session was confirmed.

Session II: Review of intake and follow-up forms included explaining each item to be addressed and the reason why it was being asked. Discussion continued about interventive skills . Issues focused upon the resistant caller and the volunteers' fear of not knowing how to respond to questions posed. It was emphasized that volunteers would

feel more adept as they became more experienced. Areas covered included problem delineation, referrals, follow-up, and advocacy. Examples were provided by the program coordinator.

This session was particularly important in building understanding, skills, uniformity, and consistency in all areas of the service. The volunteers needed to understand how to complete the intake and follow-up forms and that it needed to be done in a standardized and consistent way for the purpose of the study. In responding to caller requests, the volunteers needed to provide three referrals, when possible, and not to provide any sort of psychotherapy over the telephone.

The meeting date for the third training session was confirmed.

Session III: Several areas were covered during this session. There was a review of the follow-up procedures. The program coordinator involved the volunteers in role playing typical I&R scenarios. The volunteers were introduced to AHA office staff. The group confirmed their respective coverage schedules. They were shown the I&R office, location or AHA literature, file space, and supplies, and were taught how to work the telephone.

The volunteers shared more personal material and discussed further their reasons for volunteering at the AHA. Two of the volunteers had experienced heart attacks and were concerned about healthy diet and lifestyles. The volunteers had a special interest in helping heart patients and their families deal with some of the stressors that accompany cardiovascular illness.

These activities were done in the hopes of making the volunteers feel as comfortable as possible in their new environment, to familiarize them with the people with whom they would be interacting, and vice versa, and with the office layout and equipment. Discussing possible I&R situations and role playing was done in order to help the volunteers build skills and confidence. Over time, it was anticipated that there would be individual growth and development through continued supervision and monitoring of the program by the program coordinator. It was hoped that the volunteers would feel comfortable working with each other and with the program coordinator and that it would foster a sense of a team spirit. It was also anticipated that the volunteers would provide feedback and ideas about the service since commitment tends to be stronger with more input. It was important that the volunteers were motivated to work in the specific health area.

During the last session, the program coordinator and volunteers scheduled their first monthly meeting.

V. DATA ANALYSIS

Data collection instrument

Data were collected on two forms, as noted earlier. The initial request for service, (intake), was recorded on the "AHA, Nassau Region Request for Information or Service" form and the follow-up was recorded on the "AHA, Nassau Region Follow-Up Form".

The first section on the intake form related to identifying information about the caller. Questions related to response, the interval between the initial call and the follow-up; identification of the caller, and when not identical, the person requiring assistance; community, to indicate the geographic area being served; age, and telephone number, in order to permit follow-up. A specific address was not requested unless literature was being mailed to the caller.

The second section on the intake form asked about the nature of the request or problem, physician availability, disposition, familiarity with the AHA, permission for follow-up and volunteer comments. Physician availability related to the fact that medical questions may need to be directed back to the caller's physician or a referral may be needed. Disposition indicated what information or referral was suggested. The AHA, Nassau Region was interested in knowing if or how people knew about the AHA as a place to call for assistance. The AHA wanted to ensure that a follow-up would occur only if permission were granted and to explain that the AHA wished to evaluate the effectiveness of the service. The follow-up was to be completed within a reasonable period of time, two weeks, in order for people to have the opportunity, for example, to follow through on a referral or review the literature. Service providers comments

provided a place for volunteers' thoughts, comments, reactions, concerns, and questions that could be addressed by the program coordinator during monthly volunteer meetings. The volunteer signed his or her name at the bottom of the page.

The follow-up form was dated and completed for each call. The date of the initial request and the follow-up call were compared in order to determine the amount of time that elapsed between the initial call and the follow-up.

The name of the person reached was noted to ensure that the initial caller had been reached. The intake form already indicated if a referral had been made, and if so, the caller was asked if he or she had followed through with the referral. If the response was yes, the caller would be asked what the outcome of the referral was in order to determine whether or not the caller was given appropriate information. If the response was no, the caller was asked what the reason(s) was for not following through with the referral. It needed to be ascertained what prevented the caller from following through, or perhaps the caller was not able or capable to follow through, or perhaps, the problem had been resolved and there had been no need for follow through. If another individual or agency had been contacted there was a need to identify this information and find out if it was helpful or not. This would also be a way to add to the resource file. When asked if the caller felt helped by the service, if the response was yes, the caller was also asked what type of help was received and what was most helpful. If the response was no, the caller was asked what type of help was expected. In terms of rating the help received, it was necessary to determine if the I&R received was accurate and responded to the caller's request and if the volunteer projected a warm, friendly, empathic, and helpful personality.

The ratings were categorized as poor, average, good, and excellent. It needed to be decided if the caller needed any further I&R which would be given at the time of the follow-up. When asking if the caller would recommend this service to others, he or she would be asked what could be done to improve the service if the response was negative. The volunteers had the opportunity to note any issues, concerns, or questions. Lastly, the volunteer handling the follow-up would sign the form.

As noted previously, data were collected on two forms from October, 1989 through March, 1991. During that time, there were 604 original requests for information or referral; of these, 149 received follow-up.

Analysis of all calls

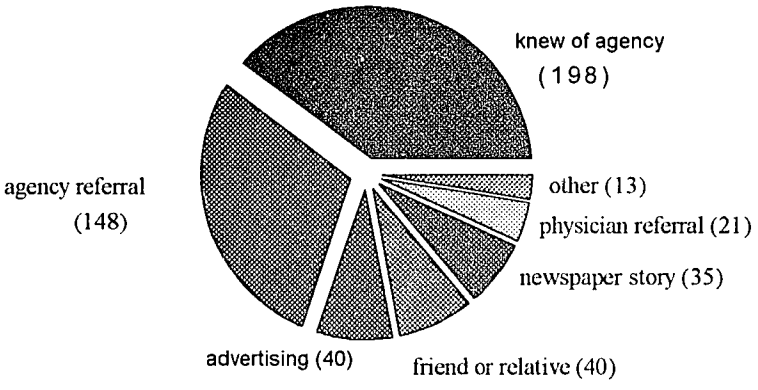
There were 604 calls during the span of the project. An intake form was completed for each call and they were arranged in chronological order. Of these, 558 were able to be logged in an effort to determine if any patterns presented themselves regarding volume and time periods of calls received at the AHA, Nassau Region.

January and June 1990 showed a surge in calls, but overall, the volume of calls remained relatively stable with no growth in volume as time progressed.

There was an overwhelming number of calls (307) from persons requesting information and/or referral for themselves, with 127 requests for service for a relative. Requests on behalf of a spouse numbered 63. Therefore the majority of callers, 82% or 497, requested help for themselves or for someone close to them.

The greatest number of calls (163) came from the age group 60-69. The age group 70-79 represented 91 calls and the age group over 80 was for 14. Therefore, about 44 % or 268 calls were from and/or for senior citizens.

The source of the calls were not concentrated in any particular sector of the agency catchment area. Most of the calls originated within Nassau County, averaging one to five calls each from over sixty cities, villages and other areas within Nassau County. Over 40 calls originated in Suffolk County, and an additional number, slightly over 40, from Queens County. A few scattered calls originated in more distant locations, as far away as Westchester County.



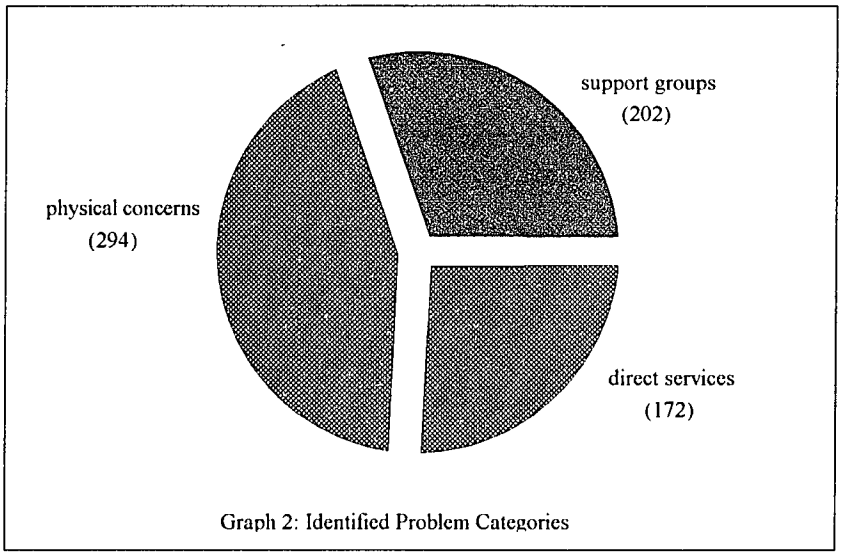
Graph 1: How Callers Learned of Service

Callers were requested to identify about how they learned about the service. As shown in Graph 1, the largest single group of callers knew about the AHA's existence and the call was simply referred to this project. This category comprised 198 calls. The second largest number of callers were agency personnel calling on behalf of clients, (148). No other category was close to these two categories. The balance of the callers

identification of how they learned about the service fell into five additional categories. These categories were advertising (40), friend or relative (40), newspaper story (35), physician (21), and other (13).

The clustering of categories respecting how callers heard of the service suggests that advertising was not effective, accounting for only about 8% of the calls. By far, the greatest number of calls came from people who already knew of the agency either as workers in other agencies or as the lay public.

In response to the question whether the caller or client had a physician, the overwhelming number answered in the affirmative: 451 or 75% of the total.



Graph 2: Identified Problem Categories

The problems identified by the callers were arrayed in 16 categories. The most frequently requested related to cholesterol (125), and the least , bereavement (3).

The problems did not appear to cluster primarily around primary heart queries. The categories included physical concerns, direct service, and support groups, as shown in Graph 2.

Health related questions centered around cholesterol (125), heart information (104), blood pressure (38), and stroke information (27).

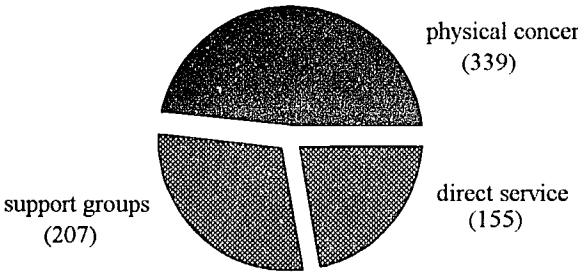
Support group categories included requests respecting heart clubs (74), stroke clubs (75), quit smoking (34), and stress management (19).

Direct service categories included cardiac rehabilitation (41), nutrition and diet (36), physician referral (35), drug related (22), counseling (21), exercise and fitness (14), and bereavement (3)

An additional 19 calls were not classifiable.

The disposition of the calls included response time and nature of the response. Most of the calls (432), received a response on the same day. This includes calls in which a volunteer was available to take the call, or if none was immediately available, the response was made before the end of the day. Since there was a discrepancy in cases such that a few volunteers did not identify response time, the same day figures represent an absolute minimum. Of the calls that did not receive the same day response, forty-eight were answered the next business day. The balance of the calls received a response in two or more days.

The disposition of the calls fell roughly into the categories of the nature of the calls themselves; physical, support groups, direct service, and others. Callers were referred to other agencies, provided with the information requested, and/or provided with a referral in order to obtain additional information and service. Various recommendations were made for many of the problems addressed.



Graph 3: Disposition by Identified Problem Categories

As shown in Graph 3, disposition closely paralleled problem categories.

The largest single category was physical, as would be expected. However, this category represents a broad range of different sorts of referrals. The largest single number of referrals was to hospitals (123), which included blood pressure screenings. Cholesterol screenings was another large category (91), followed by cardiac rehabilitation service referrals (34), and in some cases, requests for physicians or the best facility for a particular procedure. This referral was also made when the caller expressed concern about an acute condition. On occasion, a request necessitated further investigation which resulted in a referral outside of Nassau County.

Callers were also advised to listen for radio announcements and to scan local newspapers in order to obtain additional information about cholesterol and blood pressure screenings. However, they were cautioned to ascertain that the resource was reputable, or to consult with a physician. A "call-back" folder was maintained with names and numbers of callers. If the I&R staff learned about a health fair or new screening date, attempts would be made to reach the callers.

Callers requesting a physician were referred to the Nassau Academy of Medicine (54). Callers were looking for a specialist or another physician either because of dissatisfaction with their own doctor, desired a second opinion, or simply because they were new to the area and needed a doctor. In some cases (37), it was suggested to callers that they ask their own physicians. Some examples would include questions about specific symptoms; side effects or complications of medications, or detailed information about particular illness.

A large number of callers were referred to various support services. Heart and stroke clubs made up the bulk (156) of these referrals. In addition, referrals were made for help to stop smoking (51).

The direct service category included referrals for stress management and counseling (47), to social workers in various hospitals (4), fitness programs (19), and nutrition and diet services (13), including the AHA, Nassau Region's Dial-a-Dietician service. A miscellaneous category would include a referral (72) to a variety of other social agencies such as the County Health Department, Visiting Nurse Service, the Red Cross, and the American Lung Association. Certain questions regarding financial, nursing home, and home care concerns were handled by referral to agencies such as the Department of Senior Citizen Affairs, Services for the Aging, Senior Citizen Hotline and the Department of Social Services.

Agency workers contacted the AHA, Nassau Region in order to obtain referrals for their clients. One agency worker, upon learning there was no known resource in his

community, created a stroke club to serve his clients and families. This program was added to the I&R's stroke club list.

Relatively few callers requested literature, however literature was sent in a total of 105 cases. Literature included information specifically related to heart and stroke, but also included fitness, smoking, blood pressure, cholesterol, diet and other matters.

The total number in the various categories is higher than the total number of calls because of some multiple requests.

Analysis of follow-up calls

It was the original intent of the project to have follow-up on each case within two weeks. Volunteers randomly selected cases for follow-up as time permitted. By the end of the project, volunteers had made follow-up contact on 149 cases. Since there were 604 original cases, the follow-up contacts represented approximately 25% of the total. In all but two cases, the respondent was the original caller. In one instance, a social worker had left the agency, but a co-worker was able to respond to the follow-up. In another, a visiting relative had gone back home.

Analysis of the number of weeks between the original contact and the follow-up revealed no clear pattern. The number of follow-up contacts made in fewer than two weeks was only thirteen. In fact, two cases did not receive a follow-up contact until 32 weeks after the original call had been made.

In a number of instances, more than one attempt was necessary in order to make contact. Of the 455 cases in which no follow-up contact was completed, at least three

attempts were made to follow-up in 165 of these cases. Follow-up contact was not attempted for the remaining 290 cases. Telephone numbers were not included on some of the intake forms, some callers did not want or feel it was necessary to receive a call, and some callers were obviously annoyed that they did not receive the information sought.

In the follow-up contact, the volunteers followed the questions on the follow-up form provided for the purpose.

All follow-up contacts were initiated with a question either about the referral in an attempt to see if the referral was followed or a general query as to the type of information or help that had been sought. The volunteers referred to the intake forms in order to ascertain what had occurred during the initial call to the AHA, Nassau Region office. In 136 cases, the respondent indicated that a referral had been made. However, the responses were not always with accordance with intake information sheet. In three instances callers stated that no referral had been made even though a referral was identified on the information sheet. In thirteen instances no referral had been made.

Of the 136 cases in which referral was made to other agencies or programs, 87 respondents or approximately 64% reported acting on the referral. As noted in the previous section, referrals were made to physical, support, or direct services.

In the category of physical referrals, respondents reported having undergone cholesterol testing, blood pressure screenings, attended cardiac rehabilitation services, and so on. For support services, respondents indicated having made contact with heart and stroke clubs, and stop smoking programs. In the area of direct service referrals,

respondents reported contacts with stress management programs, hospital social workers, nutrition counselors, etc.

On 49 occasions, individuals did not follow-through on referrals given for a variety of reasons. These were organized under categories; medical, situation, motivational, and other.

There were eleven reasons provided under the "medical" category: five spoke with his or her own physician and did not feel the need to pursue any further help; five respondents indicated that they were "feeling better"; and one respondent stated her husband had improved, but was again feeling depressed and she needed to follow-up with the referral(s).

Under the "situational" category eleven different reasons were provided: two respondents reported that the patients had passed away, therefore, no reason remained for them to obtain resources; three needed resources located in a more convenient place and time; two people had been visiting a relative and returned home before attempting to seek assistance; three individuals went out of town and had not yet sought help, and one person was waiting to undergo cardiac surgery before joining a heart club.

There were sixteen reasons provided by respondents that would be considered under the "motivational" category: ten respondents "had not gotten to it", but wanted to; and six respondents were not interested in following through. Most did not give more specific reasons. In a few instances, someone else had called on behalf of the client/patient and it was the client/patient who was not interested in the referral.

There were eleven reasons given under the "other "category: three respondents did not acknowledge having been given referrals; four respondents read the literature and did not feel it necessary to pursue the referral; two respondents decided to continue with their own physician and not make any changes; and two respondents indicated that the individuals for whom the referral had been sought were already attending programs and did not wish to make any changes.

One hundred thirteen callers did not make contact with facilities other than those referred to them by the I&R service. Twenty-six respondents reported contact with agencies, programs, or individuals other than those to which they were referred. Five contacted hospitals regarding heart or stroke clubs, cholesterol screenings, other types of support groups, and medical information. Six contacted other agencies for information such as Medicaid, Medicare, and senior citizen centers. Not all were found to be helpful. Five contacted their physicians to help with a referral and all reported that their physicians were helpful. Five indicated seeking help elsewhere, but the specific place was not recorded nor was the outcome, except in one case. Five secured physicians on their own initiative. The question about alternate referral contacts was inadvertently omitted in ten follow-up calls.

In the follow-up calls volunteers asked questions about the response of the caller to the service. In eleven cases the volunteer either neglected to ask the question or did not record the response.

Of the 149 follow-up calls 140 provided a rating of the service. Nine were not recorded on the forms. The rating response requested included excellent, good, average,

and poor. Forty-eight respondents rated the service as excellent; seventy-five found it good; nine thought it average; and eight rated it as poor. The respondents placed the service above average as either good or excellent in 88% of the cases.

Sixteen reported that they did not feel the service had helped them. The reasons for dissatisfaction varied. In some cases, the callers had requested information which could only be provided by a physician. In ten cases, the caller wanted an AHA endorsement for specific hospitals, physician, medication, or procedures which would have violated AHA policy or the law, or both. In a few cases, callers reported that the agency to which they had been referred was not helpful.

The nine out of ten callers who reported being satisfied with the help they received from the service found it beneficial for various reasons. In most of the cases, all the caller had been seeking was a referral. Typical of these was referral to an agency, hospital, club, or support service. The support services were found to be consistently helpful. Callers indicated that the information in the literature was more extensive than that provided by the volunteer. As a rule, callers expressed appreciation for service received at time of the original contact and also for the follow-up contact, which they said indicated interest and concern by the AHA, Nassau Region.

They reported that obtaining a specific referral was helpful in giving them a feeling of being able to "do something" about the problem. Receiving different kinds of information and alternative choices was found to be empowering. Even some of the respondents who did not follow the referral given reported that the service was helpful.

They, as well as many who did follow-up on the referrals, indicated they experienced relief from "just be able to talk to someone".

The volunteers were trained to provide additional information or referrals during the course of the follow-up contact. On fifteen occasions, the volunteers provided this help. These included five referrals in the "physical" category, six referrals in the "support service" category, and four referrals in the "direct service" category.

The volunteers recorded the responses of 136 cases to the question whether they would recommend the service to others; 130 said that they would, yielding over a 95% positive response. For those who would not recommend the service, it had already been noted when they had indicated dissatisfaction, as well as what would have been considered improvements.

Volunteers comments

On both the intake and follow-up forms, an area at the end was provided for volunteers to comment on the cases. These comments were reviewed to see if any patterns emerged which would reflect the attitudes of the volunteers toward the callers, the service or their own reactions. No clear pattern could be discerned.

Comments reflected the gratification felt by the volunteer if the caller expressed appreciation of the service; and distress if the caller was critical of the service.

Volunteer comments encompassed a broad range of reactions. Some simply noted that the caller was very upset at the time of the call. Others reported that the caller seemed to simply wish to ventilate and did so at great length.

Volunteer comments included a variety of recommendations by callers such as the idea that the AHA, Nassau Region should provide a physician referral list as many hospitals do. A number of callers felt that the AHA, Nassau Region should rate doctors, hospitals, medical procedures, and various programs.

Comments on the initial information sheets and the follow-up sheets were similar except to the extent that follow-up responses sometimes rated both the follow-up call and the initial service. The follow-up contact provided some respondents with the opportunity to rate the quality of the referral, as well as the value of the overall service. Curiously, a few callers expressed appreciation for the service even though they had not followed through on the referral provided.

Volunteer performance

Fifteen volunteers were recruited during the program. Of this group, nine stayed with the program on a regular basis. They included active and retired business people and professionals, community people, senior citizens, and homemakers.

During on-going supervision at the monthly meetings, problems focused upon volunteers' skills and appropriate responses to callers. Interventive techniques were discussed regarding the handling of problem situations such as callers who were upset, angry, or agitated. The group members provided emotional support, sharing of new resources and information, as well as having common bonds and goals.

The volunteers worked to improve the project by organizing records and literature, updating the resource files and creating lists of frequently requested referrals. They shared

reactions to callers, as well as their opinions about the I&R environment. The group also shared articles on cardiovascular disease as a forum for discussion. Their feedback was used to inform project modifications. Often, volunteers remained after the formal monthly meetings to talk informally among themselves. Volunteers attended the meetings on a regular and consistent basis.

As noted, there was some turnover of volunteers, requiring more than one recruitment effort followed by training. Over the course of the project, there was an average of two to four volunteers working on the phones at any given time. From the original group, two volunteers stayed with the project from its inception to its conclusion. They were joined by a third volunteer approximately six months after the project was initiated, forming a core group of three who remained throughout the project. The volunteers expressed interest in being involved in mentally challenging work, learning about new areas in the health field, as well as helping other people.

On occasion, a caller learning that the service was staffed by volunteers, offered to be a part of the program and in one case the offer was accepted.

The inherited resource file was incomplete upon initiation of the project. One task of the volunteers was to insert new information into the file as it became available. Accuracy of referral sources needed to be checked. Inaccurate information was to be deleted or updated as appropriate. Essentially, new files were created and maintained consisting of 1) informational material such as brochures, pamphlets and articles and 2) referral sources. An American Heart Association manual that addresses questions about

heart disease, stroke, cholesterol and other heart and stroke related issues was included as a useful reference source for volunteers.

Despite the training sessions for volunteers, information recorded by them on the forms was sometimes insufficient and unclear. For example, a telephone number might be omitted or permission for follow-up not obtained.

VI. CONCLUSIONS

Usefulness of the service

Problems obtaining adequate heart and stroke information are the main concerns of callers. Patients and families also need emotional support. Callers are often distressed after being informed of a diagnosis. Finding information or help is often stressful. It is often difficult and costly obtaining information and support from the physician because doctors are not readily available to respond to the patients' concerns and they may inadequately respond to patient psychosocial needs.

The project was undertaken in order to explore the use of a telephone I&R service in order to provide information to the community. This service was to address the mission of the AHA to provide a distinct measurable service to the community in a caring and cost effective manner; to relieve the busy AHA staff of the responsibility and chore of speaking to those with problems; to provide information; to engage in education and prevention activities; to identify client needs; to identify needs and gaps in service; and to enhance the positive relationships between the agency and the public. This service went beyond providing information, as it offered the caller opportunity for interactive exchange that may have ramification for assistance beyond concrete I&R. It provided access, immediacy, and personal attention. It was organizationally manageable and evaluable.

It was decided to have the service provided by volunteers because of its cost effectiveness and in fulfillment of the AHA's policy of engaging in worthwhile community service related to the organization's mission. The project sought to learn if volunteers could be used effectively in this project.

This project demonstrated the feasibility of designing and implementing a telephone information and referral service. It utilized the manpower of trained volunteers, supervised by a professional. The service was convenient, provided assistance, without fee, to the general public, and permitted callers to control the extent to which they could, if they wished, remain anonymous. Information, referral, and assistance were provided in a cost efficient and effective manner.

The telephone access provided a convenient entry for the public. Need was confirmed by the fact that more than 600 calls were received during the course of the project. The ease and convenience was demonstrated by the volume of calls.

The project covered over a calendar year and, as noted, there was no particular pattern regarding service use during a particular period or season, nor was there a steady growth. The two points in which there was a surge in calls was in January and June, 1990. In fact, January, 1990 showed a high in the number of calls, 49, compared to a low in January, 1991 of twenty-two calls.

Of these 604 calls, follow-up calls were made in 149 cases or 25% of the total. The positive response to the service was about 90%, indicating that the agency goal of providing such service was met. Although the goal of enhancement of the community's positive perception of the agency could not be measured directly, it may be inferred that an overwhelmingly positive perception of the service would result in an enhancement of public perception of the agency. Moreover, the findings in follow-up calls, that two thirds of the callers had taken action on the referrals and information given them, would suggest that they found the information and referral useful.

The goal of protecting caller anonymity was found to be unnecessary. Callers identified themselves readily and the follow-up calls confirmed that accurate self-identifying information had been provided.

Occasionally, a caller wished to remain anonymous, which obviously precluded any follow-up. The volunteer did not always discuss follow-up if a caller was obviously angry with the volunteer's response. Callers who were pleasant, despite their problems, were easily asked by the volunteers for permission for follow-up. Completing the follow-up was problematic when individuals were not at home. Messages were left on answering machines indicating that the American Heart Association had attempted to make contact and that a future effort would be made to reach the caller. Whether or not there was an answering machine, contact would be attempted no more than three times. Within the first few weeks of the beginning of the project it became apparent that there was not enough manpower to followup on the calls within a two week period or at a given time on a particular day. Limited manpower for follow-up also contributed to the many of the 290 cases in which follow-up had not been attempted. In general, there was no way to calculate whether the timeliness of the follow-up affected the nature of the callers' responses.

The vast majority of respondents (84%) stated that they were helped. It is possible that some responded positively to the concerned, friendly voice of the volunteers. It can be speculated also that some respondents who were under less emotional stress at the time of the call-back responded in the affirmative even if the severity of the problem had not altered. People also called for help during a crisis and then the problem often subsided

over the natural course of time. On the other hand, some negative responses might be attributed to such factors as deteriorating health during the interval between calls. In addition, the problem could have worsened and the response was based upon this factor.

The service was found to be particularly useful to older persons for whom transportation could be expected to present a more serious problem than for younger people. Convenience was also reflected by the extensive geographic range of the calls. Some locations would have required the caller to spend most of the day coming to the agency for the information had the service not been available.

An unexpected use of the service was peripheral to the need for specific information. It was reported by the volunteers that some of the callers appeared to simply feel isolated and needed human contact. Nevertheless, the overwhelming number of calls was for the purpose of obtaining specific information and/or referrals directly related to the AHA, Nassau Region activities and services. Most of the callers knew about the AHA, Nassau Region and would have called for information even if they had not known of the availability of the I&R service.

Often, callers would request the name of the "best" doctor to perform a particular cardiac surgical procedure or the "best" hospital in which to go for a particular procedure. Callers also wanted the "best" cardiac rehabilitation program or fitness center. Frequently, information was requested as to where to go for a free or inexpensive cholesterol "check-up". Callers did not wish to go to their own doctor and incur expensive laboratory expenses. A minimum of three referrals were provided on any one problem area, consistent with American Heart Association policy. The AHA, Nassau

Region Executive Director and Psychosocial Committee requested that the I&R service refer to hospitals and hospital-based programs whenever possible on the assumption that a person would receive quality service within an institution regulated by quality assurance standards. Although the availability of other viable resources was acknowledged, the AHA, Nassau Region had no means to evaluate other services.

Given the number of calls taken by the volunteers and the number of responses and the amount of activity in searching for information conducted by the volunteers, it may be concluded that the I&R service by volunteers relieved the professional paid staff of a great deal of non-professional/non-specialized activity, which paid staff would have been required to undertake.

In collating data on information provided and information not available at the times of the calls, the project succeeded in identifying needs and gaps in service. By locating, organizing, and filing, in response to caller requests, volunteers succeeded in maintaining and updating a resource file. The collection of the data facilitated evaluation of the service. Information included lists of local hospitals and stroke and heart clubs; cardiac rehabilitation centers and stop smoking programs. This information was regularly updated.

The lists of sources and related data organized by the volunteers became a valuable resource to the agency and showed that such activity could enhance the quality and scope of the agency's services. Furthermore, networking with other agencies was enhanced since volunteers inquired about their services and advised them of the AHA, Nassau Region's I&R service.

Gaps in service were identified but not always corrected. For example, a physician referral list was found to be needed. One was started, but not completed. Other information gaps identified: a comprehensive list for stress management and counseling; cardiac rehabilitation centers (other than those which are hospital based); support groups for family members of cardiac patients; cholesterol screening sites; and a complete referral list of sites for blood pressure screenings.

Efforts to fill the identified gaps in information and service sometimes were successful as indicated above. The lack of success in the other cases could not be analyzed systematically. The gaps were identified through repeated requests by the public. They were reported to the Psychosocial Committee. In attempting to collect the needed information, the Psychosocial Committee conducted a questionnaire survey. The questionnaire was sent to area health care professionals, other agencies, and mental health providers, in an effort to create a more comprehensive list of referral sources for the service. The response was minimal; not enough responses were received to be useful. Analysis of the efforts of the Psychosocial Committee and its lack of its success is beyond the scope of this project.

As expected, the bulk of the inquires related to the matter of physical concern. The large number of requests related to clubs and support groups may indicate the need for association with other people with shared problems, for health reasons, or it could simply be another manifestation of the isolation and apparent loneliness reported by volunteers.

The centralization of I&R service in one location obviated the need for consumers to make numerous attempts to obtain services. The program served as an authoritative source of information on cardiovascular disease for the professional community. Community agencies such as the Department of Senior Citizen Affairs and the County Office of Volunteer Services became aware of the project as a placement for their volunteers. The I&R service may have served as a catalyst to promote the networking of service agencies and health providers. Many home care agencies, rehabilitation services and institutions notified the AHA, Nassau Region of available health related services, information which the office could, in turn, disseminate to the public.

In regard to program planning, the AHA, Nassau Region's ability to address the needs of patients and their families dealing with cardiovascular disease was enhanced by the service.

Advertisement of the service was delayed at the beginning of the project and during certain intervals during the course of the project. Concern centered around having trained volunteers in place and periods of limited manpower in relationship to possible high volume of calls. Response to advertising the need for volunteers was always positive and perhaps was a way of inadvertently advertising the service.

Volunteers

The use of volunteers trained and supervised by a professional social worker achieved a measured success. Only a limited number of the volunteers recruited remained

active in the project throughout its duration. Those volunteers in the active category proved to be highly effective.

The unevenness of performance of some volunteers suggest a need to review, with a view to revision, of the system of recruitment and retention and/or the format and delivery of the training sessions. For example, the wide variation in time taken for follow-up calls suggests a need for emphasis on the importance of such calls. Some volunteers clearly resisted full completion of the forms and seemed unmotivated to do necessary paper work. It was not determined whether this was a problem of recruitment screening, or training and supervision, or some other variable.

The volunteers were highly motivated in various aspects of their responsibilities. They enjoyed the telephone contact; they actively sought and organized information; and they devoted many hours of their time, both in the agency, and in parallel activities, such as locating relevant literature for discussion and distribution. They attended the monthly meetings regularly.

The reasons volunteers dropped out varied. Some related to time and place; for example, one volunteer enjoyed the service, but annually spent several months in Florida. Another reason was that some volunteers found the work not to their liking; for example, the stress involved in working with anxious people.

Service coverage was limited due to the availability of the volunteers. Some callers did not leave their names and telephone numbers when the service was uncovered and it was unknown whether these people called back. The receptionist did not keep records of these calls. Emergency requests were rare, but on occasion a call needed to be directed to

a member of the staff. Coverage was also affected when volunteers called in sick or were on vacation.

Although not measured, random comments by paid staff expressed their appreciation of the work provided by the volunteers. It should be noted that during the planning of the project, staff expressed reservations concerning the reliability and expertise of the volunteers. These expressed reservations were replaced shortly by episodic expressions of gratitude and appreciation for the service. Increasingly, the volunteers felt accepted by the staff and sought assistance from them when needed.

Data collection

The use of the telephone in conducting the survey saved time and money in that the volunteers did not spend time with mailings nor did the agency incur mailing costs. However, a scheduled appointment to conduct the interview was not possible due to limited volunteer manpower. Even though respondents had consented to a follow-up call, the ability to reach a greater number of respondents was possibly hampered without pre-arranging appointments. None of the persons contacted terminated the interview and generally all were cordial to the interviewer. The use of the telephone also provided a means for respondents to express opinions, problems, and feelings.

Open-ended questions provide information and unanticipated answers. However, it is quite time-consuming to analyze and summarize variable answers. Furthermore, interpretation and categorization of answers is likely to be more subjective than with close-ended questions.. Closed questions provide easy data compilation. Questions need

to be asked in an unbiased manner (Epstein & Tripodi, 1977). These factors became apparent when findings were being analyzed. Although the closed-ended questions permitted easy compilation of data, the open-ended questions provided a fuller understanding of the callers' and/or volunteers' responses, situations and concerns. This afforded the program coordinator opportunity to better assess the responses and thus the service.

When evaluating open-ended questions on the follow-up form, volunteers sometimes stated the same responses for different questions. The questions were designed to obtain more specific information from the callers as the questions were asked in a progression. For example, if a caller found the service helpful, what specifically was helpful. This leads one to question whether there was a problem in how the volunteer interpreted the questions and presented them to the caller and/or the caller was not clear as to what information the volunteer was seeking. Perhaps, there was a problem in the way the question was worded. There was also repetition in the category referring to whether the caller felt helped and the question concerning what the caller would recommend to improve the service. As noted previously, the closed questions lent themselves to more efficient data collection and statistical analysis than open-ended questions. The difficulty in evaluating the responses from open-ended questions was the subjective rather than objective nature of the responses.

VII. RECOMMENDATIONS

Based on the analysis of the service, a number of recommendations is appropriate in the areas of planning, volunteer use, and organization.

Organization and evaluation issues

In the area of planning, actual start-up costs and on-going commitment requirements of the agency should be clarified. Negotiation with the agency administration should include the requirement of a long term commitment to the service. The agency commitment should involve in-service training of paid staff to understand the nature of the volunteer service; what can be expected of volunteers; appropriate relationships between volunteers and paid staff; a basic knowledge of the resources with which the volunteers will work; and the ability to undertake the work of the volunteers during times when they may not be available.

In developing an I&R service, careful attention should be given to the records, such as forms to be filled out. For example, open-ended questions can be very useful in providing profiles of an individual or families and their situations. However, it is difficult to achieve any consistency of recording. It is difficult to train volunteers to record the information in a way which makes systematic analysis feasible.

Information to be included on forms should be identified by general categories in such a way as to permit periodic modification without significant loss of needed content.

Follow-up should be pursued for all calls, including scheduling calls in advance, in order to provide continuous information about the use of the service. Supervision should include careful attention to the follow-up to ensure it is made in a timely fashion.

As part of the follow-up, updated or formerly unavailable information be provided.

Volunteers should be directed to offer literature to each caller when such literature is available pertaining to the nature of the call, since callers reported finding the literature very helpful.

The file of resources and referrals should be constantly updated and expanded. The entire file should be recorded in a way to facilitate transfer to computer to afford easy retrieval. Use of the computer for this purpose should be included in the training program for volunteers. The agency should understand the importance of having available people with necessary computer skills to facilitate the work of the volunteer.

Since the largest group of callers already knew of the AHA, Nassau Region and would have called in any event, the availability of the I&R service should be widely advertised to assure reaching members of the population who do not know of the existence of the service. Advertising should be undertaken early in the provision of service and should be designed to reach the general public. Additional advertising such as mass mailing should target other health service workers in agencies to enhance networking opportunities.

I&R services might provide a valuable field work experience for BSW students or human service program students. Such a placement could give rapid and practical education to a range of specialized and correlative services, and introduce students to

work with volunteers and to responsibilities involved in certain supervision. As noted, it would be important for students to be trained not only in the delivery of I&R services, but in the area of working with volunteers as an area of expertise. This could help reduce the possible tensions that may exist between professionals and volunteers.

Agencies which use volunteer services should provide modest recognition in a variety of forms which could include meals, reimbursement for transportation and/or award and recognition ceremonies perhaps with certificates. All volunteers should be covered by agency liability insurance policies. Agencies need a clear understanding of the commitment of time , space, and personnel which must be dedicated in order to receive the many benefits of volunteer staffed free community service such as an I&R service.

This program was intended to provide service to those residing in the Nassau County region. Review of the calls showed people were calling heavily from Nassau County; however, many were calling from Suffolk County and Queens County, and some from as far away as Westchester County. This raises the question of whether it might make sense to have a centralized service based on Long Island which would cover Nassau, Suffolk, Queens, and Brooklyn Counties.

Since it was possible to categorize the kinds of calls, perhaps it would also be a possibility for the AHA to implement a twenty-four hour I&R "800" telephone number which would serve the Long Island area. This could provide basic information about heart and stroke related issues, as well as information about programs and services in a computerized program format. For example, a person would call, hear a taped message and prompt for the specific information sought, whether it be for medical information,

literature about a variety of topics, and/or lists of heart or stroke clubs. The person could simply obtain information, request literature, and/or receive a call-back, if desired.

This approach would save time for the professional staff and eliminate the coordinating of large numbers of volunteers. One problem identified in the program was the volunteer drop-out rate and other events that interfered with reliable volunteer coverage, such as being sick and going away on vacation. The agency could identify the basic kinds of service needs and move toward this type of computer service. Since during the study there actually was a core group of three volunteers, it would be reasonable to still utilize a core group who are stable and reliable, if this type of service were to be instituted again. Of course this would necessitate on-going recruitment, training, and supervision, but there would be less time needed for coverage. The volunteers could return calls to those who wished to speak with someone and send out the requested lists of programs and literature, with no need to call back.

An objection that could be raised involves the possible concern about dehumanizing this type of service. As noted previously, there were callers who just wanted to ventilate or talk to someone. However, this was not the purpose of the service. The suggested computerized service would eliminate those who took up an inordinate amount of time speaking to the volunteers. Although their needs were great, they were not related to the service. The caller does have the option to leave his or her name and telephone number and request a call-back.

In addition to a small, well-trained group of volunteers, the service needs professional coordination, and a professional paid staff person needs to be designated by

administration to coordinate this activity. This would institutionalize the service and the program could run indefinitely. The service is not an integral part of the agency service until it is connected to a paid professional and is built into the agency diagram. One problem with the service is that it did not "fit in" any place. It needs to be a be put in the chain of command and built into the administrative structure.

This study could serve as a pilot to guide other AHA offices or social agencies in their efforts to offer similar services.

Use of volunteers and professionals

On-going supervision should be provided for an I&R service either by assignment to one individual paid staff member or collaborative arrangements which would assure that no volunteers are working without supervision.

Given the limited ability to predict volunteer availability, recruitment of volunteers should be on-going. However, careful attention should be given to screening. Perhaps part of the recruitment process should include making as clear as possible the expectations and task requirements of the job. Since part of the volunteer drop-out of the project was related to dislike of some of the task requirements, recruitment and screening should include provision, as complete as possible, of description and clarification of what the volunteer would be expected to do.

The training should include further clarification of task requirements, opportunities for role play simulation, and possibly on-the-job experiences. In cases in which this sort of service is implemented, experienced volunteers should be involved

extensively in the training of recruits. In addition, experienced volunteers could be used to great advantage in a program of mentoring, in which experienced volunteers are assigned to provide on the job training for recruits, and to serve as role models. During the course of the project, the national AHA published a manual which provides basic telephone techniques, model responses, and AHA policies which could be a valuable tool in training volunteers (AHA, 1990).

An evaluation process and form should be designed in order to evaluate volunteer performance and skills on a periodic basis.

A set of standards should be devised when using recruits to provide a mechanism provided for separating them from the service.

Where a project involves records, ongoing supervision should include monitoring thoroughness and accuracy of volunteer record keeping. This is especially important where the records are to be used for subsequent analysis and improvement of the service.

To assure continuity of volunteer services, recruitment and screening should include obtaining information about their life schedules. This may be more important where the volunteers are seniors and have partners who are susceptible to illness or special care requirements; or they have health problems of their own; or have regular periods of availability such as winter trips to Florida.

Afterward

At present, the I&R service which the project spawned, is entering its fifth year. It is staffed exclusively by volunteers with administrative assistance provided by an AHA,

Nassau Region staff member. However, unless the program is institutionalized, its future is uncertain. As of this writing, the Psychosocial Committee has requested the AHA, Nassau Region to fund the program, that is, to continue to budget operating expenses and to create a permanent, salaried position for an Information & Referral Service program coordinator. Thus far, there are no funds forthcoming for a salaried position; however, funds will remain available for the other operating expenses. The Psychosocial Committee attempted to find a professional interested in volunteering time to act as I&R program coordinator. The search was successful. There is now a social worker who has volunteered to oversee the I&R service and volunteers are providing coverage of the I&R service from 10 a.m. to 4 p.m. Monday through Friday.

Appendix A: VOLUNTEER INFORMATION FORM

American Heart Association
Nassau Region
Volunteer Information

Date_____

Name_____

Address_____

Phone #_____

Birthdate_____

Social Security #_____

Education_____

_____

Work Experience_____

_____

Other information relevant to volunteering_____

_____

_____

Days/time/hours available_____

_____

_____

Appendix B: INTAKE FORM

American Heart Association
Nassau Region
Request For Information or Service

Caller:
Date of Call:
Call Returned:

Requested for:
Community:
Phone:
Age:

1. Nature of Request/Problem:_____

_____

_____

2. Do you have a doctor? (if applicable) Yes____ No____

3. Disposition: Information/Referral/Service provided:_____

_____

_____

4. How did you learn about the AHA's I&R service? _____

_____

5. We are interested in assessing the effect of our service. May we call you back at a later date? (within two weeks) Yes ____ No ____
What day/time will be convenient for you? _____

6. Service provider's comments: _____

_____

_____

_____

Service Provider: _____

Appendix C: FOLLOW-UP FORM

American Heart Association
Nassau Region
I&R Service

Follow-up

Date: _____ Person Contacted: _____

1. Was a referral made? Yes ____ No ____
   If Yes, ask #2. If No, ask #5.

2. Did you follow through with our referral? Yes ____ No ____
   If Yes, ask #3. If No, ask #4.

3. What was the outcome? (Include any problems)

   _____

   _____

   _____

4. What was the reason for not following through with our referral? (Include any problems)

   _____

   _____

   _____

5. Did you contact anyone else or another agency not referred by us? Yes ____ No ____

   What was the nature of the help received? _____

   _____

   _____

6. Did you feel you were helped by our service? Yes ____ No _____
   If Yes, ask #7. If No, ask #8.

7. What type of help did you receive? What was most helpful? _____

_____

_____

8. What type of help did you expect? (What was missing?) _____

_____

_____

9. Rate the help received:

	Poor	Average	Good	Excellent
Information Received				
Interested Listener				

10. Is additional follow-up indicated? Yes ____ No ____
Specify:

_____

_____

_____

11. Would you recommend this service to others? Yes ____ No ____
    If no, ask how we could improve our service.

_____

_____

_____

12. Service provider's comments: _____

_____

_____

Service Provider:_____

Appendix D: NEWS RELEASE

American Heart Association, Nassau Region

News Release

For Release:

Immediate

MAY WE HELP YOU?

As part of its mission to reduce death and disability from cardiovascular diseases and stroke, the Nassau Region of the American Heart Association maintains an Information and Referral Service. Staffed by volunteers, this service is available throughout the work week.

Requests for information concerning diet, exercise, cholesterol screenings, support groups for victims of heart attacks and stroke, and their families, are but a few of the types of calls received. The residents of Nassau County are cordially invited to avail themselves of the AHA Information and Referral Service by calling _____.

Volunteers to staff the phones for the I&R Service are always needed and greatly appreciated. If anyone has available time and would like to become part of this helpful service, please call the Heart Office at _____.

Appendix E: PLANNING PROCESS NOTES

10/88 Spoke to Chairperson of Psychosocial Committee about the reinstatement of I&R service. Chair would present this to Committee at next meeting. Received call from Chair indicating the Committee's interest. Invited to join Committee and two members, including the Chair, would form a sub-committee and meet before the November meeting.

11/4/88 Letter received from President of AHA, Nassau Region to join Psychosocial Committee. Invited to attend 11/28/88 meeting. Reminder that sub-committee would meet to discuss plans for the I&R service.

11/28/88 Sub-committee meeting. Outcome: Need an I&R service, funding, and a specialized person to run an I&R service.

11/28/88 Psychosocial Committee meeting. Writer of this paper to be program coordinator of I&R project. Program coordinator to outline a proposal using AHA national guidelines provide by Executive Director (E.D.). Plan: To bring package to Executive Committee with funding ideas in place. Sub-committee to meet before next Committee meeting.

12/14/88 Sub-committee met. Started basic outline as described in handbook. Social worker seen as necessary to oversee I&R project.

12/14/88 Committee not comfortable with responsibility of obtaining funding. To be discussed further at next meeting.

1/25/89 Sub-committee met prior to Committee meeting. Committee met and summary of status of I&R provided. Program coordiantor had requested and received

cardiovascular mortality statistics dated 1/11/88 from AHA, New York State affiliate which indicated frequency of death by county and cause. A proposal for the I&R project will be given to the Board of Directors, (AHA, Nassau Region), regarding demand, level of staffing needed, and type of supervision required. Committee members started giving suggestions regarding coverage, exposure, and advertising.

2/22/89 Sub-committee met. Discussed criteria for I&R referrals, forms, preliminary write-up of proposal, advertising, training, and problem of there being no paid staff person from the AHA. Nassau Region.

2/22/89 Committee meeting. Firm commitment from Board of Directors required.

3/1/89 Sub-committee met with E.D. Goal is to demonstrate efficacy of service for agency, patients, community, and professionals. Areas discussed were utilization of service, staffing, and needs assessment.

3/29/89 Committee meeting. Reported that sub-committee met with E.D. On-going review of various proposals to balance various needs and directions. Areas of discussion have been personnel, structure, training, and supervision.

4/26/89 Committee met. Program coordinator discussed possible design of I&R project utilizing volunteers and paid staff. E.D. supported I&R program and believes a design model could be replicated in other AHA offices. Program coordinator to give written proposal to E.D.

5/10/89 Proposal submitted to E.D. which had been reviewed by sub-committee.

5/31/89 Committee met. E.D. attended and discussed. Need to evaluate current system and train volunteers and staff to handle calls. Need to design standardized forms to record

data and contact agencies for prospective volunteers. Program coordinator preparing a research design. Committee requesting a six month commitment from Board of Directors and E.D. Program Director and E.D. to meet in order to discuss proposal further and provide recommendations to the Committee.

6/28/89 Met with new Program Director At AHA, Nassau Region who is concerned about institutionalization of project and advertising.

Committee met. Proposal approved by E.D. Program coordinator contacted Nassau County Office of Volunteers who will publicize the positions. Program coordinator to meet with AHA, Nassau Region office staff to discuss the project. AHA, Nassau Region not able to provide staff to help with I&R project. Committee discussed issue regarding establishing a staff liaison. Decided to proceed with project as pilot to determine what the most successful configuration would be for a permanent program and deal with question of staffing then. Program coordinator to prepare draft of intake form.

7/26/89 Committee met. Reviewed intake form. Suggestions provided. Follow-up form to be designed. Discussed items to be included. Volunteer information form to be designed by program coordiantor. Implementation Schedule: 1. Initial training of volunteers 2. Meeting with AHA, Nassau Region staff to be scheduled for 9/89. 3. Project to start 10/1/89 5. Public service announcement to be written.

Program coordiantor to outline training program. Staff to be advised regarding the identification and screening of I&R calls.

8/30/89 Committee met. Reviewed intake, follow-up, and volunteer information forms, as well as instructions for completing the forms and training program. Refinements made.

There are volunteers awaiting training. Plan: Program coordinator to meet with AHA, Nassau Region staff 9/6/89 and have one training session with volunteers by next meeting. Target date 10/1/89. Once volunteers are committed E.D. will arrange publicity. Program coordinator to continue to contact volunteer agencies.

Fall 1989 The AHA, Nassau Region newsletter "Heart to Heart" advertised for volunteers.

9/27/89 Committee met. Program Director wants recruiting and training to be on-going. Feels professional should do this. Discussed broadening scope of concept of service to include funding a full time professional to promote and network on behalf of the AHA, Nassau Region..

Project to start October 9th. Decided to advertise service week of October 16th. Program coordinator met with AHA, Nassau Region staff. First training session completed with volunteers. Coverage of service discussed.

Final review of all forms reviewed and approved. Policy issues discussed regarding provision of I&R service. Discussed maintenance of program. Program to recruit, train, and supervise volunteers. Program coordinator to come into office each week to review completed intake and follow-up forms and address any other issues and report back to Committee. Program coordinator to meet monthly with volunteers. Office space, equipment, and clerical services provided.

Appendix F: IMPLEMENTATION PROCESS NOTES

10/10/89 Memo from E.D. to staff announcing the start of the I&R service.

10/16/89 News release sent out to recruit volunteers

10/25/89 Committee met. Report provided by program coordinator. Press releases to go out shortly. Program coordinator still recruiting. Volunteers building resource file and index. Training sessions completed.

11/29/89 Committee met. Program coordinator provided update on service. More volunteers recruited. Training sessions to be scheduled. Committee decided to wait to publicize service until after holidays when new volunteers available. Program coordinator to prepare quarterly report for next meeting.

1/3/90 committee met. First quarterly report presented. Committee decided to wait until resource file in better shape before advertising service and volunteers are fully trained. Recruiting continues. Program coordinator coming in one time per week to review completed intake and follow-up forms. Monthly meetings with volunteers have been useful and feedback will continue to be given to Committee.

2/6/90 News release sent out to recruit volunteers

2/7/90 Committee met. Program coordinator reported that work of volunteers is variable as some handle calls better than others. Need more volunteers to help update resource file.

3/7/90 Committee met. Recruiting of volunteers continuing with possible prospects.

4/4/90 Committee met. Ten people responded to advertisement for volunteers. Training sessions to be scheduled. Discussed the handling of I&R calls when volunteers unsure of response. Program coordinator is able to be reached by telephene. Committee decided to extend pilot phase of project for additional three months to allow for integration of new volunteers into the service. Six month report provided.

4/25/90 Committee met. Training sessions completed. There is a core group of six volunteers who function at variable levels.

5/23/90 Committee met. There are presently four volunteers available on a regular basis and three who are available some of the time. Coverage is being provided Monday through Thursday mornings or afternoons. Program coordinator to prepare report for next meeting to include activity to date, problems encountered, remaining problems to be resolved, and recommendations as to how best continue the program. Committee will evaluate program and make recommendations to E.D.

6/27/90 Committee met. Report presented by program coordinator.

Concerns: Getting resource directory complete and current. Possible absences or departures of volunteers.

Committee recommendations: Service requires a professional person for supervision 2-3 hours per week and volunteer training eight hours two times per year. Recruitment and training of additional volunteers should occur at least two times a year to maintain needed staffing. Service ready for publicity.

News release sent out to advertise service

7/25/90 Committee met. Chairperson to arrange meeting with E.D., prog director and program coordinator to discuss recommendations and determine how to proceed with the service. Based upon report regarding types of calls, there are recommendations to update cardiac rehabilitation list of referrals. update stress management resources, and AHA, Nassau Region should consider running a cholesterol screening as had been done in the past.

Committee drafted a questionnaire to send to providers in order to obtain information about support groups, stress management programs, and counseling referrals.

8/9/90 Met with E.D., program director, Chairperson, and program coordinator.

E.D. impressed with service He is to propose to program advisory committee of Board of Directors to request a paid consultant and look to institutionalize the service.

8/22/90 Committee met. Based on above Chairperson to prepare a budget for the proposal for E.D. to submit to committee.

9/26/90 Committee met. Volunteer resigned. Delay publicizing service. Proceding with recruitment and training of new volunteers. Service being discussed at program planning committee meeting and then will go back to Board of Directors. Committee requesting to extend project another six months. Program coordinator to submit report at next meeting.

10/17/90 Committee met. Program Advisory Board voted "wholeheartedly" to approve continuation of service. Remaining aspect is funding. E.D. discussed necessity to obtain funds to maintain service and discussed sources that AHA, Nassau Region will pursue for this purpose. Report provided by program coordinator.

11/28/90 Committee met. Chairperson and E.D. to arrange meeting with fund raising Chairperson to pursue issue of funding. Program coordinator training two more volunteers.

12/90 No meeting. Program coordinator to submit report.

1/18/91 Committee met. Report provided. Funding issue discussed. Volunteer training completed.

2/15/91 Committee met. Meeting regarding fund raising did not take place. Fund raising Chairperson unavailable.

March 1991 memo to E.D. from Committee with recommendations regarding funding and institutionalization. A budget proposal is included.

Spring 1991 I&R program written up in the American Heart Association newsletter.

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