HEALTH OF THE ELDERLY PROJECT

An Experiment in the Voluntary Visiting of old People

by

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and

LINDA HART

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Dr. D.L. Wilson (Chairman) Medical Officer of Health	from March 1971
Miss J.E.S. Brown Principal Medical Social Worker	from March 1971
Mr. D. Brown Voluntary Organisations Liaison Officer - Social Services Department	March 1971 until April 1972
Mr. F. Graham Personal Assistant to the Director of Social Services	from June 1972
Mr. M. Ridley Deputy Team Leader - Area Social Services	June 1972 until December 1972
Miss N. Roddam Deputy Team Leader - Area Social Services	from March 1973
Dr. K. Bergmann Consultant Psychiatrist in Geriatrics	from December 1971
Councillor Fallows Member, Newcastle General Hospital Management Committee	March 1971 until November 1972
Dr. E.H. Jarvis Consultant Geriatrician	from March 1971
Mrs. C. King Voluntary Services Information Officer, The Hospital Centre (for the King's Fund)	March 1971 until March 1973
Mrs. J. Boorer Voluntary Services Information Officer (temp) The Hospital Centre	from May 1973
Mrs. A.I. Reed The Organising Secretary, Age Concern Newcastle	from March 1971
Mr. R. Richardson The Hospital Secretary, Newcastle General Hospital	from March 1971
Mr. W. Morgan Department of Family & Community Medicine, University of Newcastle	from May 1973
Dr. R.L. Sanderson General Practitioner	from March 1971

Mr. A. Speirs Young Volunteer Force Foundation	March 1971 until May 1973
Mr. H. Shorr Young Volunteer Force Foundation	from June 1973

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CHAPTER ONE

THE HEALTH OF THE ELDERLY PROJECT

1.1 BEGINNINGS: INIATING THE PROJECT

In April 1970 Mr. Anthony Steen, the Director of Young Volunteer Force Foundation, approached the King Edward Hospital Fund with an idea for a two year experimental Project. He presented the Project as having a four-fold aim, these aims being complementary to one another:

1. Developing experimental after-care and preventative medicine with patients, their friends and families.
2. Helping to develop relationships that bridge the gap between family, friend and hospital patient.
3. Expanding the existing voluntary service that was already taking place inside a number of hospitals in a city.
4. Promoting and initiating voluntary support and training for specialised tasks.

It was proposed that the experiment take place in Newcastle upon Tyne, where a Young Volunteer Force team was already well established; the work would be carefully documented and at the end of two years a detailed report would be prepared. The field team would comprise two full-time paid staff.

A period followed in which the aims of the proposed experiment were amplified and clarified[1] with support from the Hospital Management Committee of Newcastle General Hospital, the Medical Officer of Health for the city, a Consultant Geriatrician at Newcastle General Hospital and the Organising Secretary of the city's Age Concern group. Clearly, the necessary interest and support existed to put the experiment on a sound footing and a grant of £10,000[2] was given by King Edward Hospital Fund to Young Volunteer Force Foundation to carry out the work.

The Steering Panel

It was felt that the field team would benefit from the help of a body of professional people concerned with health and welfare. Such a "Steering Panel" would meet regularly to discuss and advise upon the progress of the project on the basis of reports submitted by the field team; each individual member of the panel would also endeavour to support the work of the Project in his or her official capacity. During the following two years the Steering Panel met regularly every two months. Mrs. Linda Hart and Mr. David Kettle were appointed as field staff in consultation with the Steering Panel.

Work was started in the summer of 1971 on "The Health of the Elderly Project". The inner West End of the city, catchment area to Newcastle General Hospital, was designated as the Project Area. Following negotiations by the Health Department, headquarters for the field team were provided rent and rate free in a hall attached to a branch library in the heart of the area.

Training and Support for Staff: The Role of Young Volunteer Force Foundation

Having initiated the Project, Young Volunteer Force Foundation undertook a three month programme of induction training for the field team. It provided supervision to assist the field team in understanding the aims of the Project and incorporating them into workable plans; valuable meetings were held with the organisers of the Croydon Project, Voluntary Work at St. Thomas' Hospital, London, and the Walthamstow Social Responsibility Centre: and supervision in Newcastle was provided by Mr. A. Spiers of Young Volunteer Force Foundation, and Mrs. Reed of Age Concern, Newcastle.

The continuing part played by Young Volunteer Force Foundation deserves mentioning at this point. As is the Foundation's policy with all its field teams, provision was made for the appointment of a Project Consultant, a task undertaken in the Project by Mr. Gary Craig. The Foundation also has facilities for providing information, for research consultancy, and for publications, upon which the Project has drawn. For example the publications department have produced a booklet about the Health of the Elderly Project for local distribution.

1.2 THE PROJECT AREA

The area selected for the experiment is roughly $1\frac{1}{2}$ square miles in size and loosely termed the inner West End of the city. It is an area well recognised as having those social problems so often associated with poverty and poor housing. Much of the area is in some stage of redevelopment. It embraces the areas known as Elswick, Arthurs Hill, Benwell, the southern part of Fenham and Cruddas Park. Each of these areas has its own character: Elswick is in the throes of urban renewal, and presents some of the most intractable problems; Arthurs Hill and Benwell comprise mostly streets of terraced houses scheduled for modernisation or redevelopment in the coming years, and both retain a fair degree of the 'community spirit' of old; the West Road sharply divides Benwell from Fenham, where gardens are more in evidence around semi-detached housing; while down towards the river from Elswick lies Cruddas Park, a complex of high rises and modern tenements. Amongst the plethora of organised groups to be found in the area are 20 churches, with their youth clubs, wives groups and over-60s clubs; 10 social clubs; 3 local tenants associations and an adult education centre.

Provision for the Elderly

Approximately 36,000 people live within the Project Area; of these about 5,000 are aged at least 65 years; the figures from the 1971 census for the whole city suggest that just under 2,000 of these are aged 75 years or over. They may attend one of 11 over-60s clubs and tea clubs and 6 luncheon clubs, the majority of which are affiliated to Age Concern, Newcastle. Several of the luncheon clubs provide voluntary transport for those unable to come under their own steam. Age Concern, Newcastle also organises one Day Centre; day care is also provided at several residential homes and where appropriate at Brighton Clinic, a Psychogeriatric Assessment Unit linked to Newcastle General Hospital. The General Hospital itself lies within the Project area: its Geriatric Unit draws many patients each year from the area and, as is usually the case, large numbers of elderly patients are also to be found on the orthopaedic and other wards of the hospital. The Project area constitutes nearly the whole of the region covered by one area Social Service team and, in addition, about a third of the area covered by another team. 46 General Practitioners serve the area: 16 of these are based at Health Centres and 8 of the remainder work together in a large group practice. During the time of the Project, Health Visitor attachment has been extended to all General Practitioners: the Health Visitors comprise 4 teams based at Clinics. One other clinic, outside the area, also serves a number of patients living inside the area, and smaller numbers involve two further clinics. Altogether

19 Health Visitors have a sizeable number of elderly patients in the area; there are also 3 Geriatric Visitors, qualified as SRN's, who carry larger caseloads of elderly people.

1.3 LAUNCHING THE PROJECT

During the initial three month period of preparation, the field team discussed their brief with a number of professional people who were either to be concerned with the Project or were working with the elderly people in the area. These discussions formed the basis of the working relationships on which the Project was to build, and through these, plans were formulated for the Project along the following lines:

(a) The Project's purpose was to explore new ways of working with volunteers in hospital and community settings. This would mean retaining a flexibility in approach so that whenever methods of working failed they would be discarded and others tried in their place. For the same reason the number of volunteers was restricted to 100 so that more attention might be given to the quality of what was being achieved[3].

(b) The Project was to be a demonstration: it was hoped that others would be able to learn both from the successes of the experiment and from its failures. A pre-requisite of this would be careful documentation. This need to monitor directly every aspect of the work of the Project suggested a central form of organisation, rather than one which would work indirectly by establishing local care groups[4].

(c) It is well recognised that a large proportion of admissions to geriatric units arises as much from social factors as medical ones[5]. Could local people be mobilised to tackle some of the root causes of these 'social admissions'? How effective would this be? The Project was to set out to answer these questions. Thus it would be working with a very frail group of elderly people: those who enter hospital and are likely to come home again, and those who are at risk of hospital admission through insufficient basic care at home. It would involve organising local visitors to provide both continuing 'preventive' support for these people in their homes and after-care when they were discharged from hospital[6]. These visitors were likely to find that their relationships with elderly people would lead them to give practical day-to-day help; an emphasis was placed on this practical aspect of visiting.

(d) Almost all elderly people have at least a few relatives, friends or neighbours who play an important part in their lives. Any efforts to improve the level of care for an old person were likely to involve contact with these people; and if the Project could play a part in sparking off new relationships of this kind, by involving local people, a natural and effective form of help would ensue. Such an arrangement would stand very much in contrast to a scheme in which voluntary visitors were brought from a different area and background. While in some ways the Project might be described as a community service scheme, it also has a strong community development aspect[7].

(e) It was a premise of work that people engaged professionally in the welfare of old people would know of those 'at risk' and would be ready to refer them to the Project for help. Accordingly the team would need to explore ways of liaising with the different professional workers so as to encourage referrals. In particular there was interest in the role which General Practitioners might play in making referrals.

Together the above considerations may be conveniently taken as an outline for the Project. Work was commenced in November 1971 when the systematic recruitment of local visitors was

started. During the first few months referrals for help were taken only from the Geriatric Unit of Newcastle General Hospital and a small number of Health Visitors, in order to concentrate on other aspects of the work. Other professionals were then approached and the Project took shape as described in the following chapters.

Recording Procedures

Details of every person referred to the Project for help were recorded at the time of referral. Following personal assessment by a field worker and any necessary action, the forms were then filed in one of 7 categories. The outcome of the first 200 referrals to the Project over 18 months is shown below:

TABLE 1A: DISPOSAL OF 300 REFERRALS FOR HELP

Referrals for Ongoing help :	1. Help accepted and visitor placed	91
	2. Help refused or assessed by Project staff as not needed	103
	3. Referred to another agency for help	13
	4. Abortive - no assessment necessary due to change of situation	25
Referrals for 'one-off' help :	1. Task executed	58
	2. Referred to another agency for help	5
	3. Abortive - help not subsequently required	5
		300

Each elderly person for whom a visitor had been arranged was then allocated a file and any developments in the visiting situation were fully recorded there. Small cards giving basic information about each visitor were also used, on which the dates of allocation to and withdrawal from a specific visiting situation were recorded. In addition, two visual aids assisted field staff in maintaining an up-to-date picture of the visiting scene. The first was a large-scale map of the area displaying the location of those elderly people being visited and of the Project visitors, distinguishing between those presently active in visiting and those not. Staff found this a valuable aide-de-memoire when identifying a visitor who lived close to a newly referred elderly person. The second visual aid was a graphdex display chart which provided an immediate record of who was currently being visited, and by whom (the names of elderly people were coded simply).

1.4 RESEARCH AND THE EVALUATION OF WORK

When the Project commenced its work in November, 1971, there were no carefully laid plans for the compilation of statistical data to assist in the evaluation of work. Instead, the first six months of activity (ending in May 1972) were designated a pilot phase, during which time staff were to formulate such plans from their experience of setting up and running the Project.

Criteria of Success

It was proposed that a criterion of success was whether the Project could lower the rate of hospital admission amongst those elderly with whom it was involved. However, experience in the first 6 months suggested that the converse effect might be more clearly observable - for

there were emerging cases of elderly people in need of but resistant to hospital treatment, with whom a visitor had helped in overcoming the patient's fears and encouraging hospitalization. Such occurrences seemed likely to cancel out any long-term trends to keep others out of hospital.

A Control Group

Careful consideration was given to the possibility of identifying a control group for those receiving help. However, the only apparent way to acquire valid control would have been to take half of those referred for and subsequently accepting help - and not provide them with help. This was felt to be ethically unacceptable: it was likely to have a deleterious effect upon relationships with those referring elderly people to the Project, and the figures thus gained would be too small to permit safe conclusions.

It was therefore accepted that evaluation of the work of the Project should take the form of

(a) The observation and recording of statistical data which common experience associates, to varying degrees of certainty, with the happiness and well-being of elderly people;
(b) The descriptive recording of a number of incidents and processes involving elderly people and their visitors.

The statistical data was mostly collected through the use of questionnaires, which are described below:

Questionnaires to Elderly People

A questionnaire was devised to investigate characteristics of the elderly people referred to the Project - their independence, and their dependence upon friends, neighbours, relatives and statutory provision; their social activities, and some aspects of their physical capacity. The information collected was restricted to objective data demanding no technical assessment skills.

This questionnaire was administered by field workers in May 1972 to the elderly people receiving visitors at that time, and subsequently to new people receiving visitors until a total of 50 questionnaires had been successfully completed. These subsequent questionnaires were completed about a month after visiting had commenced. The 50th questionnaire was completed in January 1973, at which time some 300 people had been referred to the Project.

TABLE 1B: COMPLETION OF 50 QUESTIONNAIRES WITH THOSE ELDERLY PEOPLE RECEIVING ONGOING HELP

	Questionnaire completed	10
	Refused to complete questionnaire	1
	Not administered from human considerations	1
	Personality disorders - unreliable answers	1
	Confused	4
	Deaf	2
	Aphasic	1
(a)	HEP visitor insufficiently involved	8
(a)	HEP visitor withdrawn previous to May 1972	9
(a)	Referred after completion of 50th questionnaire	2
	TOTAL STILL LIVING AT HOME	79
	No longer living at home *	12
	TOTAL RECEIVING ONGOING HELP	91

* 4 had died; 1 had entered long-stay hospital; 6 had entered residential care and 1 had moved in with relatives.

Plans to repeat this questionnaire at 5 monthly intervals in order to assess the effects of organised visiting, were later modified and one follow-up interview was completed in April 1973. This recorded certain basic changes in the lives of these 50 elderly people which might be related to the involvement of Project visitors.

Pressure upon field staff time had precluded the execution of similar questionnaires with those who refused help or did not need it: however, late in 1972, through the co-operation of Mr. John Davies, a lecturer in Social Studies at Newcastle University, the opportunity emerged to gather information about this group with the help of 22 students who were willing to administer questionnaires. These were subsequently administered in March 1973 as follows:

TABLE 1C: COMPLETION OF 67 QUESTIONNAIRES WITH THOSE NOT RECEIVING ONGOING HELP

Location of elderly person		Completion of questionnaire	
Died	13	Questionnaire completed	67
Entered long-stay hospital	2	Refused to complete questionnaire	8
Entered Residential Care	3	Confused	4
Joined relatives	2	Deaf or aphasic	4
Still at home	83		83
TOTAL	103		

In order to permit comparison between this group and those who received help, questionnaires were also completed with as many as possible of those in the '(a)' groups in Table 1B.

However, it is important to realise that differences in the timing of the interviews with these two groups may limit the validity of comparative studies between them, which should therefore only be taken as indicators of differences and similarities present.

In particular comparisons between patterns of neighbourly support have been minimal. The interviews with those receiving help were conducted by field staff who had a relationship with the interviewee by virtue of having introduced a Project visitor. The detailed questionnaire about who called in and what they did was answered well for field staff, but there are strong indications that repondants were less explicit in this area of questioning when students were conducting the interview. A small number of test interviews by others with those whose patterns of neighbourly support were well known to field staff has supported this suggestion.

The Questionnaire to Visitors

In order to gain detailed information about Project visitors and the range of activities they had undertaken with the elderly, a postal questionnaire was distributed and followed by an interview by a staff member. Both parts of the questionnaire comprised a 'background' section and an 'activity' section - one copy of the latter was completed for each elderly person with whom the visitors had ongoing contact.

TABLE 1D

Questionnaires completed	90
Visitor moved out of area, unable to contact	9
Ill at time of questionnaire	2
Refused to complete questionnaires or Project staff failed to arrange meeting with visitor	10
TOTAL NUMBER OF VISITORS	111

All questionnaires were processed on an IBM 360-67 computer through the co-operation of the Medical Research Unit of Newcastle University. The analysis is described in greater detail in Appendix B.

1.5 PLANS FOR THE FUTURE

The grant provided by the King Edward Hospital Fund expires in March 1974. There is agreement amongst all parties concerned with the Project that the work should continue beyond this date. Alternative ways of ensuring this have been discussed and it has been felt that the Project would integrate well with the work of Age Concern Newcastle. This option is presently being pursued: the Executive Committee of Age Concern Newcastle have approved proposals drawn up by its Organising Secretary to seek the necessary finance for three full-time staff to perpetuate and develop the work. A rolling expansion programme is proposed which would attach teams of local Project visitors to new Health Centres: it is envisaged that Project staff would find an administrative base alongside other Age Concern staff within Local Authority Social Service Area bases. The Project's close links with hospitals would also be carried into new areas of work.

Finance is to be sought from Age Concern (National), from the new Area Health Board, from Local Authority Social Services and through the Urban Aid programme.

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1. the major considerations determining the direction of the project are described in 1.3 below.
2. this was later increased to £11,200
3. this would eventually give each field worker responsibility for about 40 active visitors at any given time - a figure which corresponds with that recommended by Barbara Shenfield, 1971 (p. 170)
4. A scheme of the latter kind is described in 'Neighbourhood Care and Old People', Cheeseman et. al. 1972
5. c.f. for example Isaacs 1971
6. c.f. the need for work in this area is well illustrated by Skeet, 1971.
7. this is explained more fully in Section 3.1.

SUMMARY - CHAPTER I THE HEALTH OF THE ELDERLY PROJECT

The Health of the Elderly Project was founded in 1971 with a grant given by the King Edward Hospital Fund to Young Volunteer Force Foundation. Two full-time staff were employed to conduct the two year experimental project in Newcastle upon Tyne, in the west end of the city.

The project set out to encourage local people to visit and give practical help to frail isolated elderly people, particularly those admitted to hospital or in danger of future admission for 'social' reasons. This demanded close liaison with professional Health and Social Service staff. During the first fifteen months of operation, 300 elderly people were referred for help to the Project. Following careful assessment, 91 old people were visited regularly by Project visitors, who numbered 111; 68 others received help with one specific task.

Detailed questionnaires were completed by interview with 63 elderly people introduced to Project visitors and with 67 people for whom visitors were not arranged, in order to study their individual characteristics - including their dependence upon relatives, friends and neighbours, and state services. Follow-up interviews were conducted with 40 old people to measure certain changes in their lives since the introduction of a Project visitor. Questionnaires were also completed with 90 Project visitors: these provided information on the visitors, their activities through the Project, and their opinions on certain topics.

Plans have been laid for the work of the Health of the Elderly Project to continue and develop within Age Concern Newcastle, and negotiations are in progress to secure the finance for this.

CHAPTER TWO

THE ELDERLY PEOPLE

2.1 THE PEOPLE TO REACH

The Health of the Elderly Project has set out to reach a group of elderly people who are likely to be 'at risk':

(a) those admitted to hospital and likely to be discharged home again, and
(b) those in danger of hospital admission at some time in the future through lack of basic care at home.

More precisely, within this group the Project has directed its attention to those individuals who are dependent, in the sense that they have difficulty in performing certain basic tasks of day-to-day living, such as shopping, cooking and lighting the fire; but who do not have these 'basic care' needs met adequately by relatives, neighbours, friends and statutory provision. Such people are also likely to be more isolated than other elderly. Unfortunately, owing to limited numbers, it has not been usual to ask Project visitors to undertake 'friendly visiting' only. There are many old people for whom isolation leads not only to loneliness but also to physical hardship, and it is these people who have been given first priority in the Project.

2.2 REQUESTS FOR HELP

Two kinds of help have been sought from the Project: 'ongoing' help where a regular practical role for a Project visitor is foreseen, and 'one-off' help with a specific task or problem.

Requests for Ongoing Help

Table 2A shows the nature of help requested for 194 elderly people[1] :

TABLE 2A : NATURE OF REQUESTS FOR ONGOING HELP

Nature of requests	No. of requests
Escorting	18
Pushing in a wheelchair	5
Regular transport e.g. to elderly relatives	9
Cooking meals	10
Shopping	40
Other specific practical roles	11
'Supervising' *	2
Friendly visiting	8
Role not specified	91
	194

* sitting with an incapacitated old person to enable their housemate to go out.

In practice, an assessment visit by Project staff has often revealed an unanticipated role for a visitor, and other specific roles emerge from time to time after visitors have been introduced to elderly people. For example, a rather vague referral concerning a fiercely independent old couple threw up on assessment a place for a Project visitor sitting with the chairfast old lady while her 82 year old husband played bowls - a game which he dearly loved and had been prevented from playing for some time by his wife's deteriorating health. Visitor activities such as this which enhance what remains of old people's independence have been considered particularly valuable. Requests for escorting to the shops, regular transport to visit elderly housebound friends and relatives, and pushing out in a wheelchair to do shopping have been specially welcomed by the Project. With the latter, however, high steps and slopes are a recurring problem, and some old people who show anxiety about going out are dissuaded on many visits by damp or cold weather.

Even cooking a meal can enhance an old person's independence if a visitor encourages her to prepare easy parts of the meal herself. Such meals have sometimes become a regular social occasion, particularly when visitors are young; typical was a diabetic lady, unable to eat Meals on Wheels, for whom a student teacher cooked a meal each Saturday. Fuller details of the activities undertaken by Project visitors are given in Section 4.2.

A small number of referrals were for temporary help: for example, while the more independent of an elderly pair is ill, or while a neighbour who usually helps an elderly person goes on holiday.

Of the 194 people above, 91 subsequently received ongoing help. Those who had been referred for specific tasks other than shopping were most likely to receive ongoing help from the Project (three-quarters), whereas half this proportion (three-eighths) of those referred for shopping subsequently received help. This supports the impression of Project staff that people making referrals sometimes suggest shopping as a visitor's role when they do not have a clear idea of what a visitor might do. Those who were unable to specify a role for a visitor made the least successful referrals - less than a third of the elderly people referred in this way then received ongoing help. It is clearly important that, whenever possible, those who refer old people for organised visitors should try to envisage what this will achieve. This point is returned to in Section 5.2.

It would be convenient if those 103 people not receiving help divided into those who did not need help and those who needed help but refused it. In practice, however, the help offered by Project staff during an assessment visit has depended upon the identification of a role for a visitor, which is valuable to the old person, reasonable in its nature and in the time it will demand from a visitor, and is not already being performed by others without undue strain; and the decision by the old person whether to accept or refuse help has in turn depended upon the nature of the help offered. For example, it is probable that many of those who were not provided with help would have accepted a friendly visitor, whereas this was not in fact offered them for reasons outlined in 2.1. above.

The relationship between the Project's assessment of the need for a visitor and an elderly person's acceptance of this is shown in Tables 2B and 2C below

TABLE 2B : RESPONSE OF ELDERLY PEOPLE AND OF PROJECT STAFF TO AN ASSESSMENT VISIT (those introduced to Project visitors)

		Elderly person's response*			
		+	0	-	TOTAL
Staff response**	+	44	17	0	61
	0	16	14	0	30
	-	0	0	0	0
	TOTAL	60	31	0	91

*Key : (elderly person's response)

+ firm and grateful acceptance of help

0 readiness to accept help, but no positive emotional response

- reaction against offer of help

** Key : (staff response)

+ definite valuable role for visitor exists

0 uncertainty as to value of placing a visitor

- help unnecessary and possibly damaging

TABLE 2C : RESPONSE OF ELDERLY PEOPLE AND OF PROJECT STAFF TO AN ASSESSMENT VISIT (those for whom Project visitors were not arranged)

		Elderly person's response*			
		+	0	-	TOTAL
Staff response**	+	0	0	12	12
	0	4	12	33	49
	-	4	10	28	42
	TOTAL	8	22	73	103

It is noticeable that of those old people who were strongly opposed to help, Project staff felt this would have been of definite value to 16% of them, and possibly of value to a further 45%. Such elderly people show a spirit of independence which expresses itself in a reluctance to accept help. It is only possible in a minority of cases to say that an elderly person's strong spirit of independence is being destructive to his or her wellbeing.

On the other hand, of those old people who should definitely not have Project visitors in the opinion of staff, a small number - under 10% - were strongly in favour of help and another 24% appeared quite willing to accept help. This points to a small but recognisable group of old people who may show neurotic or hypochondriac tendencies.

The relationship between these two scores and the destination of elderly people on follow-up is shown below :

TABLE 2D : RELATIONSHIP BETWEEN ELDERLY PERSON'S RESPONSE AND STAFF RESPONSE TO AN ASSESSMENT VISIT AND DESTINATION OF ELDERLY PERSON ON FOLLOW-UP

Elderly person's response	Destination on follow-up: Died	Entered institutions	Still at home	TOTAL	χ^2_4	p
+	7	8	52	67		
0	4	10	37	51	10.2	<0.05
-	11	2	60	73		
TOTAL	22	20	149	191*		
Staff response						
+	7	12	54	73		
0	12	8	58	78	9.8	<0.05
-	3	0	37	40		
TOTAL	22	20	149	191*		

* One no information and two in general hospital during follow-up period.

Those people who had been strongly against help were marginally more likely to have stayed in the community than others and less likely to have entered institutions: in a similar but more marked fashion those assessed by staff as not to have Project visitors were most likely to have stayed in the community - 92% did so compared to 73% of the others.

Project Staff Action

The statistics to be found in Chapter 4 of this book describe the activities of Project visitors. They do not include action taken by Project staff, and no systematic record has been kept of this, although in certain cases it has been of some importance. Negotiations concerning statutory provision and rehousing problems are recurrent examples of this.

However, records have been kept of action taken by Project staff on behalf of those 103 elderly people who were not subsequently allocated visitors: and are shown below by precedence :

TABLE 2E : ACTION TAKEN BY PROJECT STAFF ON BEHALF OF THOSE ELDERLY PEOPLE NOT INTRODUCED TO PROJECT VISITORS
(by precedence)*

Arranged services or appointments	7
Made queries concerning existing services or appointments (e.g. querying reductions in services, arranging transport for chiropody, etc.)	6
Contacted professional worker concerning a specific problem or problem area (e.g. concerning rehousing, financial problems, admission to residential care)	17
Contacted relatives, neighbours, shopkeepers etc. concerning a specific problem	6
Contacted commercial agency (e.g. to terminate a H.P. agreement on a gas cooker)	4
TOTAL	40

* In seven of these cases action was taken in more than one of the above categories.

For the remaining 63 people action was limited to explaining to the person who made the referral the outcome of the assessment visit.

Referrals for 'Once-off' Help

The major part of this report concerns the provision of ongoing help to the elderly through organised voluntary visitors. However, 68 of the first 300 referrals to the Project concerned a task or problem requiring a specific action:

TABLE 2F : NATURE OF 68 'ONCE-OFF' JOBS REQUESTED

20 were requests for transport to appointments
13 were requests for furniture
11 concerned help with packing etc. during rehousing
6 were requests for help with practical tasks within the house
4 meant queries with official bodies
4 were requests for temporary check visits
3 housebound people wanted a haircut

and the remaining 7 requests were varied.

The majority of transport jobs involved taking elderly people to the opticians. There is no doubt that this causes difficulties for many elderly people, and inability to visit an opticians can be distressing. One old lady who received ongoing help had lost her glasses during a hospital stay and for six months had gone without her two favourite pastimes of sewing and reading, until Project staff discovered this on assessment and arranged transport to an opticians for her. Statutory transport to opticians or opthalmic clinics[2] could be a valuable development in this field.

As the Project has temporary storage space in a hall, limited amounts of furniture have been accepted as gifts and redistributed. Beds, gas cookers, armchairs and chests of drawers have been in greatest demand amongst those being rehoused. Rehousing raises special problems for the elderly[3] who lose the support of neighbours who have helped them for many years when they

move. The mentally ill are particularly vulnerable. In one case a schizophrenic old man who stayed in his terraced house until it had become detached found this burned down by vandals and was rendered temporarily homeless. In another case a mentally ill lady referred by a shop-keeper had lived on a war widow's pension for several months since a visiting officer from the department of Health and Social Security had failed to find her in on a number of occasions: he had decided the house was derelict, she was considered itinerant and her supplementary benefit had been stopped.

These 'once-off' jobs should not become the central task of an organised visiting scheme, but in moderate numbers it is felt that they encourage visitors, both those active and those awaiting introduction to an elderly person, to feel more involved with the Project, and more aware of the needs which constantly arise amongst elderly people who live around them.

2.3 PEOPLE AT RISK - THE PROJECT ELDERLY

Details of the age, sex and marital status of elderly people referred to the Project for ongoing help are shown in Tables 2G and 2H: comparison has been made with studies of 300 new elderly referrals to a welfare department in south London[4], and with a cross-national survey[5]

TABLE 2G : AGE OF ELDERLY REFERRALS (Percentage distribution)

Age	H.E.P. (n = 186)	'Helping the aged' (n = 300)	Cross-national survey (n = 4,067)
Under 60 years	3	- *	- **
60 - 64 years	6	- *	- **
65 - 69 years	14	- *	35
70 - 74 years	17	22	29
75 - 79 years	19	32	20
80 - 84 years	25	25	10
85 - 89 years	13	16	4
Over 90 years	3	5	
TOTAL	100	100	100
Total over 80 years old :	41%	46%	14%

* this study was restricted to those aged over 70
** this study was restricted to those aged over 65

41% of the people referred had passed the age of 80, which is a similar proportion to that found in the 'Help the Aged' study (46%) and in the PEP[6] study (42%).

TABLE 2H : SEX AND MARITAL STATUS OF ELDERLY REFERRALS
(percentage distribution)

	H.E.P. (n = 188)	Helping the aged (n 300)	Cross-national survey (n 4,065)	65+ in Project area (n = 5,010)
Men	21%	26%	40%	37%
Women	79%	74%	60%	63%

	MEN			WOMEN		
	H.E.P. (n = 39)	Helping the aged (n = 79)	Cross national survey	H.E.P. (n = 149)	Helping the aged (n = 221)	Cross national survey
SINGLE	15	12	4	17	14	14
MARRIED	31	35		15	12	
WIDOWED/DIVORCED SEPARATED	54	53	96	68	74	86
	100	100	100	100	100	100

Men were under-represented: this was also found in the P.E.P. study where 19% of those interviewed were men. Perhaps this is because men are less likely to outlive their spouse than women are [7], but the relative difficulties of establishing a voluntary visiting arrangement with old men may also have inhibited their referral to the Project. This point is returned to later.

Household Composition

As might be expected those living by themselves constituted the largest group of people - two-thirds lived alone, a similar proportion to that found in the 'Helping the Aged' study. And almost one quarter lived with one other equally aged person - either a spouse or a sibling. Invariably if one of the pair fell ill, the other faced special problems too. The 7 sons who lived with an elderly person often had difficulties themselves. One in particular was a recluse, and another had been recently released from a mental hospital.

TABLE 2I : HOUSEHOLD COMPOSITION OF ELDERLY REFERRALS
(percentage distribution)

	H.E.P. (n 194)	Helping the aged (n 300)
Living alone	68	64
With spouse only	15	15
With sibling only	7	*
With son	4	*
With daughter	1	*
With one other	3	*
With two or more others	3	*
	100	

* comparable figures not available owing to different methods of grouping data.

Physical Capacity *

Physical incapacity was slightly more prevalent amongst those referred to the Project than in the 'Help the Aged' study. A similar proportion were unable to prepare a hot meal - 25% in the Project compared to 26% in that study - and 12% were unable to make a cup of tea, compared to 9%.

TABLE 2J: PERSONAL AND HOUSEHOLD CAPACITY OF OLD PEOPLE
(percentage distribution)

Physical incapacity	H.E.P. (n = 130)	Helping the aged (n 300)	Cross-national survey (n 4,183)
None or slight (0-2)	31	38	76
Moderate (3-6)	39	62	15
Severe (7+)	30		9

* Derived from Townsends personal and household capacity score. See Appendix C.1 question 11 for details.

Destination of Elderly People on Follow-up

The rate at which elderly people have been referred to the Project since its inception has fluctuated very little :

Months:	1&2	3&4	5&6	7&8	9&10	11&12	13&14	15&½ (16)
Number of referrals :	40	35	38	34	43	46	33	30

These figures include all referrals, but the distribution is likely to be similar for just those 194 referrals for ongoing help under consideration here. Follow-up investigations were completed in the 17th and 18th months of the Project, which means that the average follow-up period was roughly nine months, with a very wide spread :

TABLE 2K : DESTINATION OF ELDERLY PEOPLE ON FOLLOW-UP
(percentage distribution)

	H.E.P. (n = 192)*	Helping the aged (n 300)
Remained at same address	67	
Rehoused	4	
Moved in with relatives	2	
Entered supervised accommodation	5	
Total remaining with community	78	73
Entered Residential Care	9	
Entered long-stay hospital	2	
Total entered Institutions	11	10**
Died	11	16
TOTAL	100	100

* two patients were in a general hospital during the follow-up period
** including patients in hospital on follow-up.

A picture emerges of a very frail group of elderly: nearly one-quarter (42) had died or entered institutions on follow-up. Figures for the 'Helping the Aged' study, when follow-up interviews were completed after a uniform period of $10\frac{1}{2}$ months, can only be used as a very rough comparison.

Hospital Involvement

The frailty of these people is also reflected in the extent of their contact with hospitals. Frequent referrals from the Medical Social Work department of a general hospital partly explains the large numbers of people having involvement with hospitals (Table 2L). In practice referrals from Medical Social Workers accounts for 56% of those who have a hospital stay recorded below.

TABLE 2L : HOSPITAL INVOLVEMENT OF ELDERLY PEOPLE

NATURE OF INVOLVEMENT (by precedence)	No. of people	%
Entered since referral	53	28
In hospital at time of referral	44	23
In hospital within 6 months previous to referral	21	11
Contact through outpatients department	14	7
No contact	60	31
	192*	100

* no information for two people

However, elderly people referred by Medical Social Workers were not more likely to have entered hospital since their referral: 25% had done so compared to 29% of those referred from other sources.

No information was obtained concerning psychiatric conditions amongst these 194 people as a whole, but of those 91 who were subsequently introduced to Project visitors, 17 were known to have attended either a hospital psychiatric department or a psychogeriatric assessment unit. In one case a lady claimed to have received obscene phone calls and threatened suicide and was taken into a psychiatric ward; mild confusion was a more common problem, exemplified by the occasion when a staff member was nearly locked in a garage by a confused old lady.

A Comparison Between the Receivers and Non-receivers of Ongoing Help from the Project

Just under half of the 194 elderly people so far studied had been allocated Project visitors; while these 91 people showed many similarities to the remaining 103 who were not introduced to visitors, there were some differences between the two groups.

TABLE 2M : PERCENTAGES OF ELDERLY REFERRALS RECEIVING HELP RELATED TO VARIOUS CHARACTERISTICS

	n	Receiving Project visitors	Not receiving Project visitors	TOTAL	χ^2	D.F.	p
SEX		n 87	n 101				
Male	39	39.5	61.5	100	0.8	1	n.s.
Female	149	48	52	100			
AGE		n 91	n 95				
Under 70	74	54	46	100			
70 - 74	82	44	56	100	1.6	2	n.s.
80 plus	30	50	50	100			
HOUSEHOLD COMPOSITION		n 91	n = 103				
Living alone	132	52	48	100			
With spouse or sibling only	42	43	57	100	7.6	2	<0.025
With others	20	20	80	100			
PHYSICAL INCAPACITY		n = 62	n = 67				
None or slight	40	37.5	62.5	100			
Moderate	51	51	49	100	3.3	2	n.s.
Severe	38	58	42	100			

Those living alone were most likely to receive help, and those living with a spouse or sibling were more likely to receive help than the remainder who lived with one or more children: those with no more than a slight degree of physical incapacity were the least likely to receive help, and those with severe incapacity were more likely to, but these trends did not reach statistical significance.

TABLE 2N : LOCATION ON FOLLOW-UP AND HOSPITAL INVOLVEMENT OF ELDERLY REFERRALS (percentage distribution)

	Receiving Project Visitors	Not receiving Project Visitors	χ^2_2	D.F.	p
LOCATION ON FOLLOW-UP	n = 89	n = 102			
Still at home	73	82			
Entered institutions	17	5	7.3	2	<0.05
Died	10	13			
Total	100	100			
HOSPITAL INVOLVEMENT	n 91	n 101			
Admission since	37	19			
No admission	63	81	7.3	1	<0.01
Total	100	100			

Follow-up investigations showed that those not receiving help were more likely to have stayed in the community than those who had been given help, and were less likely to have entered institutions[8]. They were also twice as likely to enter hospital as those not receiving help. Other differences emerge between the pattern of support characteristics of these two groups, and these will be discussed shortly.

2.4 LIVING - WITH HELP

A voluntary visitor rarely becomes the most important individual in an elderly person's life immediately following her introduction. As a rule, old people who have lost the ability to perform some basic daily tasks are accustomed to having help with these tasks from relatives, friends and neighbours, and from services provided by the state. We now turn our attention to these various sources of help and study their place in the lives of the elderly people referred to the Project.

TABLE 2O : DO YOU DO ANY SHOPPING YOURSELF (percentage distribution)

ANSWER (%)	Receiving Project Visitor	Not receiving Project Visitor	TOTAL (n = 127)
Yes, today or yesterday	28	41	35
Yes, longer ago	20	12	15
No	52	47	50
	100	100	100

The dependence of these people upon others for practical help was clear. Half those asked said they did no shopping for themselves, and a third of the remainder had not been to the shops on the day of the interview or on the previous day; of 60 people receiving Project help who were questioned about cooking, a quarter said they did no cooking for themselves. From whom did these people usually find help with these and other tasks?

Help from the State

Home Helps were the most common form of state provision to the elderly people interviewed: three-quarters of them were attended by Home Helps. One quarter received Meals on Wheels, a slightly larger proportion had a Bath Attendant, and two-fifths received Chiropody. Of the latter, nearly half received domiciliary visits from their chiropodist which is more than double the proportion for those treated by Local Authority Services in the city as a whole.

TABLE 2P : PERCENTAGE OF ELDERLY IN RECEIPT OF VARIOUS STATUTORY SERVICES

	n	Receiving Project visitor	Not receiving Project visitor	TOTAL
Home Helps	130	79*	67	73
Meals on Wheels	129	31	22	26
Bath Attendant	130	33	25	29
Chiropody	130	48	36	42

* including one private help.

Each of the above services was slightly more in evidence amongst those old people being visited through the Project. This may be connected with their slightly greater incapacity compared with those not introduced to Project visitors. Amongst those receiving Meals on Wheels, the frequency of deliveries to these two groups was similar - nearly half received them on 4 or more days of the week. However, the frequency of Home Help visits was significantly higher amongst those being visited through the Project (Table 2Q).

TABLE 2Q : FREQUENCY OF VISITING BY HOME HELPS (percentage distribution)

Frequency of visits	Receiving Project visitor (n = 49)	Not receiving Project visitor (n = 45)	TOTAL	
Once weekly	8	36	21	$\chi^2_2 = 10.51$
Twice weekly	69	49	60	$p < 0.01$
More often	23	15	19	
	100	100	100	

The Old and their Services

TABLE 2R : FREQUENCY OF HOME HELP AND MEALS ON WHEELS SERVICE - OPINIONS OF 130 OLD PEOPLE

Expressed need for service	HOME HELP			MEALS ON WHEELS		
	Receiving Project visitor	Not receiving Project visitor	Total	Receiving Project visitor	Not receiving Project visitor	Total
Not provided - doesn't want	12	18	30	40	49	89
Not provided - would like service	1	4	5	3	3	6
Service provided - sufficient help	31*	36	67	11	10	21
	63	67	130	62	67	129*

* including one private help * one no information

Satisfaction with the Home Help service varied greatly. Many had a very good relationship with their Home Help. There were eight instances of Home Helps coming back in their own time to do further work; and one-quarter of all elderly people attended by a Home Help said she took away things to do in her own time, such as a list of shopping to do or some washing. This was twice as common amongst those being visited through the Project as amongst the remainder: the same was true of those who said they would like to have their Home Help more often, and these two facts were probably related.

In the same way, some elderly people loved their Meals on Wheels while others grumbled about them: 34 people received the service, while 16 others used to have Meals on Wheels but no longer had or wanted them: seven of these had cancelled their meals because they disliked them and four others said they had done so because the meals arrived too late. The figures are small but they suggest that further thought needs to be given to the preparation and delivery of these meals.

How Services had become Arranged

Many people had been dependent upon state services of one kind or another for some years, and it is not surprising that they had difficulty in recalling who had arranged these services for them. Of 105 people attended by a Home Help, 71 recalled who organised this with greater or lesser certainty. The majority of these people (63) referred to professional Health and Social Services staff: most often the old person thought this had been done by the doctor, but "the Hospital" and Health Visitors and Social Workers (with some confusion between the two) were also frequently mentioned. In seven other instances, relatives were said to have arranged the service, and in only one case was a neighbour quoted. Similarly, as far as people could recall[9], professional Health and Social Service staff had organised almost all Meals on Wheels, Bath Attendants and most Chiropody - five people said they had organised the last service themselves, two of these with Private Chiropodists. It appears that whatever steps have been taken to teach people about the services available to the elderly, the onus has in practice lain with professional workers to see that these are provided where they are needed. While relatives have sometimes requested services on behalf of old people, it seems that neighbours rarely consider such action within their scope[10].

Had there been any special factors sparking off the arrangement of these services? Three-quarters of those visited by Home Helps mentioned specific crises which had led to the provision of this service. Forty three people said they had fallen ill at home; 20 first had a Home Help following discharge from Hospital; and 9 said that their housemate had become ill, and in some cases later died. It was reassuring to find that the frequency of visiting by a Home Help did correlate with the physical incapacity (Table 2S).

TABLE 2S : RELATIONSHIP BETWEEN PHYSICAL INCAPACITY IN OLD PEOPLE AND THE PROVISION OF A HOME HELP

	TOWNSEND'S PERSONAL AND HOUSEHOLD CAPACITY SCORE			
	0 - 2 mild incapacity or more	3 - 5 moderate	6 + moderate or severe	(n - 92)
No Home Help	20	7	8*	
Home Help: once weekly	9	6	5	
Twice weekly	10	20	26	
More often	1	6	11	

* five of these lived with someone else and two others were visited every day of the week by an active neighbour.

Some of those people being visited through the Project had relied upon a Home Help for many years (Table 2T (1)) and had been attended by a succession of Home Helps (Table 2T (2))[11]. There are inevitably adminstrative problems in providing the same Home Help to an individual from the rehousing of an old person, from her admission to hospital for a while, or from increases in Home Help hours when her health deteriorates. But if a Home Help is to be anything more than an extension to a vacuum cleaner, a continuity of relationships is to be pursued.

TABLE 2T (1) : LENGTH OF PROVISION OF A 'HOME HELP' TO ELDERLY PEOPLE VISITED THROUGH THE PROJECT

	Number of people
Under 1 year	7
1 - 5 years	19
5 - 10 years	14
over 10 years	7
	47 *

* no information for 2

TABLE 2T (2) : NUMBER OF HOME HELPS (excluding temporary) ATTENDING IN SUCCESSION TO 49 PEOPLE VISITED THROUGH THE PROJECT

One or two	18
3, 4	11
5 or more	10
	39*

* no information for 10

Attention from Professionals

Less than half those interviewed said that they were visited regularly by their doctor: the remainder had to call him on any occasion when they wanted to see him. However, twice this number - four-fifths of those questioned - said that they had seen their doctor within three months previous to the interview.

TABLE 2U : WHEN DID YOU LAST SEE YOUR DOCTOR?

	% (n = 128)
Within 1 month	65
Within 1 - 3 months	15
Within 3 months - 1 year	12
Over 1 year	8
TOTAL	100

As one might expect, those with little or no incapacity were much less likely to be visited regularly by their General Practitioner; however, over half had nevertheless seen their doctor within one month, compared to three-quarters of those with moderate or severe incapacity.

TABLE 2V : RELATIONSHIP BETWEEN PHYSICAL CAPACITY AND WHETHER DOCTOR CALLS REGULARLY

	DOES DOCTOR CALL REGULARLY?		
Physical incapacity score	Yes	No	Total (n = 128)
% 0 - 2 (slight or none)	17.5	82.5	100
% 3 - 5 (moderate)	42	58	100
% 6 plus (moderate or severe)	56	44	100
% Total	40	60	100

At first sight it may seem alarming that half of those with moderate or severe incapacity, most of them living alone, should not be visited regularly by their doctor. However, Health Visitors are now attached to General Practitioners in the city, and regular visiting is undertaken by them on many occasions when the doctor does not do so. Three-fifths of those interviewed said they were visited by a Health Visitor. Again there was often confusion between Health Visitors and Social Workers who were said to visit one quarter of those interviewed. This confusion was sometimes aggravated, particularly in crises, by visits from a number of other official people, and it is felt preferable to preserve continuity in relationships between elderly people and at least one or two professional workers. Preventive Health Visiting can serve this purpose where it is practised; if doctors are to maintain a similar role, special steps will be necessary to enable this to happen in group practices. One strategy which assists in this is the organisation of General Practitioners work in pairs, thus limiting patients contact to two doctors only.

Help from within the Community

It is by no means easy to discern with accuracy the part played by relatives, neighbours and friends in the lives of individual old people: perhaps only an old person's best friends know these things. Certainly a large number of people referred to the Project have refused help because that help is already being given, apparently unknown to the professional worker making the referral, by a friend or neighbour. And from time to time Project visitors learn about neighbours who help the elderly person they visit, but of whom Project staff did not learn on their assessment visit.

The prime aim of the Project has been to enable those referred to it to be helped, and caution has been necessary where a research operation has seemed likely to damage important relationships with old people. For this reason, one method of investigating the help old people received from neighbours was discarded: that of asking them to record in writing each person who came into their home during a week. Instead, Project staff asked about these sources of help as part of a lengthy questionnaire which was administered about one month after assessment, by which time a Project visitor had often been placed. It is felt that the relationships which Project staff had established with elderly people at this stage helped in obtaining accurate information about relatives, neighbours and friends.

In contrast, the questionnaires administered later by students to those elderly people not introduced to Project visitors lacked this background and there are grounds for suspicion that these people were not forthcoming about this area of their life. Several cases arose where an old person had made no mention of someone well known by Project staff to be visiting her frequently. Therefore the findings in this section are drawn only from 60 people who were introduced at some stage to Project visitors, and who had been interviewed by Project staff.

These 60 visitors were asked for details about every person who called in to see them at least once a week. Each visitor was placed in one of six categories: housemates, relatives, friends and neighbours, Home Helps, Project visitors and Professional workers.

HOUSEMATES - fifteen of those 60 elderly people interviewed did not live alone and in these cases information relating to visitors was also sought concerning housemates.

RELATIVES visited 24 of the 60 elderly people every week. Nearly one third of old people said they had no relatives living in the city at all and over half had no children living in the city (Table 2W (1)). The latter proportion was a little higher than for those other 67 people interviewed who had not been introduced to Project visitors.

TABLE 2W(1) : THE RELATIVES OF 63 ELDERLY PEOPLE RECEIVING PROJECT VISITORS

	Elderly people 0	1	2	3+	TOTAL
Number of same generation relatives living in city (by household)	39	13	4	7	63
Number of first generation relatives living in city (by household)	34	13	8	8	63
Number of first generation relatives not at work all day	46	8	3	5	62
Number of all relatives living close to elderly person*	32	17	7	7	63

* estimated as being within 15 minutes by bus from the elderly person.

TABLE 2W(2) : THE RELATIVES OF THOSE RECEIVING PROJECT VISITORS COMPARED TO THOSE NOT RECEIVING PROJECT VISITORS (percentages)

Characteristics of elderly :	Receiving Project visitor	Not receiving Project visitor	
% with no same generation relatives living in city (by household)	62	64	n=130
% with no first generation relatives living in city (by household)	54	42	n=129
% with no first generation relatives not at work all day	74	70	n=126
% with none living nearby	51	31	n=128
% having no relatives with cars	78	66	n=130

Similarly, this group were less likely to have relatives living in the same part of the city. This is probably why, in this group, the most frequent visitor to an elderly person was less likely to be a relative than it was in the group not receiving Project visitors.

TABLE 2X : NATURE OF MOST FREQUENT VISITORS TO ELDERLY PEOPLE

	NUMBER OF ELDERLY PEOPLE	
	Receiving Project visitor	Not receiving Project visitor
Relative	6	23
Friend or neighbour	29	26
Home Help	16	12
Project visitor	1	0
TOTAL	52	61

86 FRIENDS AND NEIGHBOURS were the most numerous of visitors to elderly people. Patchy information was obtained from old people about 79 of these visitors together with 44 who visited old people for whom a Project visitor was not being arranged[12]. Over one-third of these visitors called on 6 or 7 days of the week, a similar proportion visited on one day of the week, and the remainder on several days:

TABLE 2Y(1) : FREQUENCY OF VISITING BY 123 FRIENDS AND NEIGHBOURS OF THE ELDERLY

Once weekly	46
2 or 3 days weekly	21
4 or 5 days weekly	9
6 or 7 days weekly	47
Total number of friends & neighbours	123

The old people said that they had known over half of their visiting friends and neighbours for more than 20 years, which shows the stability of their relationships with many visitors. On the other hand, the manner in which people respond naturally to the needs of the elderly may be illustrated by the fact that the old people had become acquainted with one-quarter of their visiting friends and neighbours within the last five years.

TABLE 2Y(2) : HOW LONG HAD OLD PEOPLE KNOWN THE FRIENDS AND NEIGHBOURS WHO VISITED THEM?

	No. of visitors
Less than one year	5
1 - 5 years	22
5 - 20 years	25
Over 20 years	31
	83
No information	40

How had elderly people got to know these visitors? Information about 83 visitors was varied. Over half could recall special circumstances which had drawn them together. Eleven visitors became acquainted through some kind of 'official' capacity: for example, as a work colleague, landlady, or pupil of the old person; eight had been lifelong friends, three were voluntary visitors from schemes other than the Project; two had moved in as neighbours; and an intriguingly wide range of other incidents were referred to.

Of 48 visitors who did shopping, 22 were said to have done this since they first started visiting; another 15 had first started to shop when the old person had fallen ill. Four others mentioned other incidents which had prompted the visitor to do shopping and 7 could recall no special event which sparked this off.

TABLE 2Y(3) : WHAT BROUGHT YOU TOGETHER?

No special event	39
'Official capacity'	11
Lifelong friend	8
Visitor moved in as neighbour	4
Voluntary visiting scheme	3
Other events	18
Total	83

Many of the visitors were themselves growing old: of 80 visitors, over half were pensioners: altogether three-quarters had no paid employment. Only one-seventh had full-time jobs, reflecting the inevitable conflict between community care and full-time work.

TABLE 2Y(4) : WORK STATUS OF FRIENDS AND NEIGHBOURS (by precedence)

Workers full-time	11
Workers part-time	7
Pensioners	43
Not working	16
School pupils	3
	80
No information	43

HOME HELPS formed a vital part of the visiting scene and attended to 46 old people. Unlike neighbours and friends they usually did housework, but like them they often ran messages. Where important shopping has consistently prevented a Home Help from doing necessary housework, causing distress to the old person, the Project has sometimes been willing to place a visitor to relieve the Home Help of some of the shopping.

PROJECT VISITORS had been recently introduced to 44 elderly people: in most other cases visitors were shortly to be introduced. On a number of occasions the role of a Project visitor has taken several months to develop: for this reason, the activities of visitors indicated in the following pages are less extensive than those reported by the visitors themselves when interviewed later in the Project. 13 people were visited each week by PROFESSIONAL WORKERS - including District Nurses, General Practitioners and friendly postmen.

Visiting: The Total Picture

(a) Number of visitors

Taking all these categories of visitors into account, nearly one-quarter of the elderly people claimed that no more than two people called on them regularly each week - sometimes, a Home Help and one neighbour, for example (Table 2Y(5)). Friends and neighbours visited in the greatest numbers, but only a third or so of old people said that more than one friend or neighbour visited them weekly (Table 2Y(6)).

TABLE 2Y(5) : NUMBER OF INDIVIDUALS CALLING WEEKLY UPON ELDERLY PEOPLE

Number of visitors	Number of elderly
0	2
1 or 2	12
3 or 4	24
5 or 6	17
more than 6	6
	61

TABLE 2Y(6) : NUMBER OF ELDERLY PEOPLE VISITED BY DIFFERENT NUMBERS OF VISITORS OF VARIOUS KINDS

	Number of elderly visited by different numbers of such visitors				Total receiving such visitors	No such visitors	Total	TOTAL NO. VISITED
	1	2	3	4+				
(Housemates)	14	0	1	0	15	45	60	(17)
Relatives	14	8	2	0	24	36	60	36
Friends & neighbours	24	10	7	5	46	14	60	86
Home Help	46	0	0	0	46	14	60	46
Project visitors	43	1	0	0	44	16	60	45
Professional workers	11	2	0	0	13	47	60	15
								245

(b) Frequency of visiting

Less than one-quarter of visitors were said to call on more than three days of the week. Half the elderly people had someone who called on just about every day of the week (Table 2Y(7)). Those with moderate or severe handicap were more likely to be visited as frequently as this compared to those with little or no physical incapacity (Table 2Y(8)).

TABLE 2Y (7) : FREQUENCY OF CALLS BY 'MOST FREQUENT VISITOR'

Frequency of calls by visitor	No. of elderly
Once weekly	4
2 or 3 days	22
4 or 5 days	2
6 or 7 days	31
	59

TABLE 2Y (8) : FREQUENCY OF VISITING BY 'MOST FREQUENT VISITOR' RELATED TO PHYSICAL INCAPACITY OF OLD PERSON

	Slight or none	Moderate or severe
Once weekly	8	6
2 - 5 days weekly	13	28
6 or 7 days weekly	13	52

On the day of the interview and the previous day, just over half the elderly people (33) said they had been attended by a Home Help; half (29) had been visited by a friend or neighbour; one-fifth (12) had been visited by Project visitors:

TABLE 2Y(9) : LAST VISITING DAY FROM EACH KIND OF VISITOR

	Today or yesterday	2 - 3 days ago	4 - 7 days ago	Over one week ago	TOTAL
Relatives	12	7	5	0	24
Friends and neighbours	29	8	7	2	46
Home Help	33	6	7	0	46
Project visitors	12	10	15	7	44
Professional workers	7	3	3	0	13
	93	34	37	9	173

When the total number of visits in one week to an elderly person from each category of visitor was computed, just over one-third received seven or more visits from friends and neighbours during the week.

The smaller numbers of relatives only partly account for their less numerous visits: as individuals they tended to visit less frequently than friends and neighbours, many of them calling on one or two days of the week.

TABLE 2Y(10) : AVERAGE NUMBER OF DAYS PER WEEK ON WHICH INDIVIDUAL VISITORS CALL

Category of individual visitor	No. days/week
Relatives	2.1
Friends and neighbours	3.8
Home Help	2.3
Project visitors	1.2
Professional workers	3.5

Daily care was provided by District Nurses in five cases. The newly introduced Project visitors were least frequent in their visiting: only eight visited more than once a week. While this voluntary visiting is more frequent than in some traditional schemes, it obviously needs further development if it is to spark off care of a quality comparable to that shown spontaneously by the friends, neighbours and relatives of old people.

(c) Total number of visits received each week

The total number of visits received by an old person in a normal week exceeded six in three-quarters of cases:

TABLE 2Y(11) : TOTAL NUMBER OF VISIT-DAYS PER WEEK FROM ALL VISITORS

No. of visits from all visitors	No. of old people
0 - 2	8
3 - 6	16
7 - 13	20
14 plus	17

Figures which include those elderly people not receiving help from the Project - and therefore are to be treated with caution for reasons given earlier - show that for over half of those receiving under seven visits each week, their Home Help was their most frequent visitor (Table 2Y(12):

TABLE 2Y(12): TOTAL NUMBER OF VISITS RECEIVED PER WEEK RELATED TO NATURE OF MOST FREQUENT VISITOR

Most frequent visitor	Total no. of visits per week from all visitors	
	0 - 6	7+
A relative	10	19
A friend or neighbour	8	47
Home Help	25	3

No doubt some of these people were fairly mobile - 20 people receiving Home Helps had slight physical incapacity: obviously for such people the number of visits received per week was likely to reflect their isolation. In fact people with slight incapacity were twice as likely to receive under seven visits each week (44%) as were those with moderate or severe incapacity (22%). Nevertheless, there remained a number of elderly people for whom the Home Help was a central figure in their lives.

As a whole ELDERLY MEN also received markedly fewer visits than women: half said they were accustomed to no more than two visits during the entire week (Table 2Y(13)). The 28 men who were interviewed showed the same degree of physical incapacity as the women, suggesting that those men were in real terms more isolated than the women. Many were tragic figures and difficult to help through a voluntary visiting scheme. For some the local pub was at the centre of their lives - perhaps being the only strong link with their past life - and they daily undertook the precarious trip there and back. Transport to the local pub has been provided by some Project visitors, but it would be more effective for pubs and social clubs to encourage any customers with cars to undertake this task.

Sheltered workshops might be further pursued as a means of restoring some meaning to the lives of such old men; but there would seem to be a place for other experimental Projects to look specifically at the problems of old men living alone and explore ways of tackling them.

TABLE 2Y (13) : TOTAL NUMBER OF VISITS RECEIVED BY ELDERLY MEN AND WOMEN IN ONE WEEK

	0-2 days	3-6	7+	TOTAL	
Women	10	12	66	98	
Men	15	5	8	28	$p < 0.001$
				126	

The Activities of Visitors

What help did regular visitors to the elderly give with the basic tasks of shopping, cooking, and where appropriate, lighting a fire and bringing coal in?

The 60 elderly people interviewed said that half their visitors - 120 visitors altogether - did shopping for them. In addition to this, half these elderly people said they did some shopping for themselves. Home Helps did shopping for four-fifths of the old people and friends and neighbours

helped half of them. There was much overlap: it was common for more than one visitor to undertake shopping. The same was true of bringing coal in: it was less common for more than one visitor to light the fire or cook meals, although such practices were often complemented by the old person's own activities.

The tasks most often undertaken by the old people themselves were cooking and, where this was necessary, lighting the fire. Three- quarters of the people performed these jobs themselves, whereas about half undertook shopping and bringing coal in where necessary, which were more frequently done by visitors than other tasks.

Where a relative was visiting, he or she was more likely to do shopping than a friend or neighbour, but less likely to do so than a Home Help. Relatives, friends and neighbours, and Home Helps were equally likely to cook meals, but relatives were less likely than the others to light fires or bring in coal.

TABLE 2Z : ACTIVITIES OF 245 WEEKLY VISITORS OF DIFFERENT KINDS

	Self	Housemates	Relatives	Friends & Neighbours	Home Helps	Project visitors	Professional workers	TOTAL
Total No. visiting	(60)	(17)	36	86	46	45	15	245
No. who shopped	29	7	20	35	38	19	1	120
No. who cook	45	6	7	16	9	5	0	43
No. who light fires*	23	5	2	12	8	1	0	28
No. who bring coal in*	14	5	4	14	18	7	0	48

* 29 old people had coal or other fires.

The elderly people interviewed therefore often received help with basic tasks from a proportion of all their visitors - Home Helps, relatives and friends and neighbours alike - and specific tasks were often done by more than one visitor. A fair proportion of old people still performed tasks themselves, less frequently, and relied upon the help of visitors on other occasions.

1. The figures do not include those passed on to other agencies and situations which were abortive.
2. Suggested by Bamlett & Milligan (1963) amongst others.
3. c.f. current research by Roy Darke, Sheffield Institute of Environment Studies.
4. Goldberg, 1970: 'Helping the Aged'.
5. Townsend & Wedderburn, 1965: 'The aged in the Welfare State'.
6. Shenfield, 1971: 'The organisation of voluntary service'.
7. Indirectly, this also accounts partly for the disproportionately large numbers of single men referred to the Project.
8. See also Section 2.2.
9. This question was only asked of 50 people receiving ongoing help.
10. c.f. Section 3.5 for Project visitors opinion on this.
11. The reliability of similar figures for those not receiving Project visitors is in doubt; it is

possible that some misunderstood the question concerned, as asking "How long have you had your present Home Help?" 24 said under one year, 15 said 1-5 years, 5 said 5-10 years and one said over 10 years. However, the authenticity of the answers is supported by the fact that 17 said they had had only one Home Help, compared to 9 giving a similar reply amongst those receiving visitors. If valid, these findings reinforce those concerning relative frequency of attendance by Home Helps between the two groups, and suggest that those receiving Project visitors have been dependent for a longer time and to a greater extent upon state services than those not receiving visitors.

12. See notes about this data in Section 1.4.

SUMMARY - CHAPTER 2 THE ELDERLY PEOPLE

One hundred and ninety four old people referred to the Project for voluntary visiting were assessed by field staff: over half were found not to need the practical help of a visitor, or refused such help. Those who had been referred for help with specific regular tasks, such as escorting to the shops, were more often assessed as needing help than those referred by someone who had not specified a practical role for a visitor.

The 194 old people showed similar characteristics to those in studies by Goldberg ('Helping the Aged', 1970) and Shenfield ('The organisation of voluntary visiting', 1972). 41% had passed the age of 80; 68% lived alone, and another 22% lived with one other person of a similar age. Widowed women were the largest single group by far; men constituted only one-fifth of the whole.

After a follow-up period ranging from three to fifteen months, 78% remained at home; of the remainder half had entered institutions and half had died. Only one-third had no contact whatever with a hospital since a date six months previous to their referral to the Project, and those introduced to Project visitors were more likely to have done so than those for whom visitors were not arranged. Of 130 old people who were interviewed, the majority were in receipt of state services. Three-quarters had a Home Help, the incapacitated being more likely to have one. All the services were slightly more common amongst those elderly people introduced to Project visitors, and these people also tended to receive more frequent visits from their Home Help. Many of them had been attended by a sequence of Home Helps over a number of years. As far as the old people could recall, most services had been arranged by professional Health and Social Service staff on their behalf.

Further studies relating to 60 old people introduced to Project visitors showed that the friends and neighbours of these people were their most common visitors and half of these were pensioners themselves. Nevertheless, only one-third were visited weekly by more than one friend or neighbour.

Relatives, when they visited, tended to do so less frequently, and over half of the elderly people had no children living in the city. Compared to those without Project visitors, it was also less likely that their most frequent visitor would be a relative. Half the elderly people had a visitor who called on six or seven days of the week; for most of the remainder, their most frequent visitor called on two or three days weekly. Half of all weekly visitors did shopping for the old people.

CHAPTER THREE

THE PROJECT VISTORS

3.1 THE ROLE OF VOLUNTARY VISITORS

It is neither practical nor desirable that voluntary visitors should meet every need encountered amongst elderly people. In order to decide which needs to tackle and how to approach them, the Project has found it useful to distinguish between

1. Needs which are frequently fulfilled within relationships between elderly people and their caring relatives, neighbours and friends.
2. Needs which the relatives, neighbours and friends of elderly people are rarely able or willing to meet.

The latter group represents amongst others those needs which demand special resources of knowledge, skill and time, such as found within the medical and social work professions. Needs in the first group tend to be resolved through a fairly small number of established relationships in which one human being responds to the various needs of another, in the context of a natural and continuous relationship. In the case of the second group, it is unusual to find a continuing personal relationship as the primary initiative. The needs in this category most likely to be met are those for which provision is more 'in demand' and hence more economically and politically viable. The professions and services existing to meet these needs motivate their employees not primarily by an ongoing relationship with a client, but through a work-role reinforced by contractual payment and professional status.

Between these two groups lie those needs which are sometimes fulfilled by relatives, neighbours and friends of the elderly but which demand from others too great a commitment of time and energy. The household chores undertaken by Home Helps and the lunches provided by Meals on Wheels are examples of some such needs to be tackled by statutory services. Other such needs - including some of those for which, taken in isolation, small demand precludes the creation of an economic service - fall within the scope of voluntary community service. It should be noted that volunteers providing such a 'need-oriented' service are expected to work without either the motivation arising from an ongoing relationship with a client, or the support of a job structure. If the task of maintaining motivation in such volunteers is not given attention, voluntary service may be a stable proposition only for a minority of high motivated individuals, and problems of unreliability and a high drop-out rate among volunteers are likely to be recurrent. A sense of loyalty and obligation to an organisation have been invoked to this end in the past by a number of traditional voluntary agencies; informal membership of an active peer group has similarly been used to great effect with young people by Task Force and Young Volunteer Force Teams.

An Approach to Voluntary Visiting

The aim of the Health of the Elderly Project has been to fulfill needs which lie squarely within the first group referred to above. The value of spontaneous community care - as the activities of helping relatives, neighbours and friends of the elderly can be described - has been a premise of work and efforts have been made to spark off caring relationships of comparable quality.

Before studying the methods adopted for this purpose and assessing the extent to which this aim

has been achieved, some observations about spontaneous community care of the elderly, as it has been met by Project staff, are to be noted:

(a) Those who adopt a caring role with an elderly neighbour are initially motivated by a simple concern for him or her as a person.

(b) The motivation to continue visiting and being visited draws its strength and stability from the ongoing relationship which is then built up.

(c) Chance factors such as the proximity of an old person and a neighbour are not sufficient by themselves to lead to a caring relationship between them: this depends also on how well suited they are as personalities.

(d) Those who help elderly people usually live close to them, and often in the same street.

(e) In this way they are able to drop in easily and visiting is often done on several days of the week and, not infrequently, every day.

(f) Much support provided by friends and neighbours for the elderly is given by housewives and by active pensioners: these people most often have the time and inclination to help.

(g) Many friends and neighbours regularly undertake a practical helping role; when this is appropriate, it serves to reinforce his or her sense of commitment to the elderly person. Examples of commonly acceptable practical roles are shopping, cooking meals, lighting a coal fire and bringing coal in, but the range is wide.

These observations have had the following implications for the organisation of visiting in the Project:

(a) In the recruitment of visitors and in subsequent contact with them, Project staff have attempted to highlight personal response as a motive for helping, rather than obligation to an organisation or any other ideal. The visitor is thus responsible for determining the nature and extent of his or her involvement in any given situation, although advice on this is given by Project staff.

(b) Visitors and elderly people have been matched in an elementary way, to assist in the formation of relationships which have a life of their own, and are not simply derived from the existence of the Project.

(c) Central to the Project has been the organisation of visiting which is ongoing: by asking visitors to become involved with only one or perhaps two elderly people, stronger relationships with each have been promoted.

(d) Every effort has been made to recruit visitors living within the Project area, and subsequently to involve them with elderly people living close to them.

(e) Frequent visiting has been encouraged by usually placing visitors with one elderly person only. Visiting twice or three times a week has been quite common but it has proved difficult to instigate immediate daily visiting.

(f) Housewives comprise the largest single group amongst the Project visitors who also include representatives of many parts of the community. The desirability of recruiting active pensioners to visiting has been recognised quite late in the Project and might be given more attention in other schemes.

(g) Visitors have usually been placed where they will find a practical role, which may help both visitor and elderly person to maintain a sense of satisfaction and purpose in their relationship. Care has been taken that the tasks proposed to visitors are reasonable in

their nature and commitment. For example, such things as personal care and heavy housework have not usually been requested.

3.2 RECRUITING VISITORS

There are many different ways in which people have come to visit through the Project, but it is possible to group these into several categories: of 111 people who have joined the Project over 18 months since November 1971,

- 45 have joined following meetings in which staff have addressed groups of people.
- 23 have offered their time following the display of posters and postcards in public places, and other printed appeals.
- 19 have joined through those already visiting in the Project.
- 15 have joined on the recommendation of other people acquainted with the Project.
- 5 have been recruited through their individual contact with Project staff.
- 2 responded following publicity about the Project in the press and on radio.
- 2 contacted the Project entirely on their own initiative.

It may be observed that 84 visitors joined following personal contact of some kind, 50 of these after direct personal contact with Project staff: and 27 have joined following 'impersonal' contact. Clearly, personal contact of one form or another has been particularly important in drawing people to join the Project. The above sources of visitors are now described more fully:

Project Staff Talking with Groups

Early in the Project, a staff member approached the clergy of over twenty churches which draw their congregation from the area. Many subsequently placed appeals for visitors in their church magazines and posters were displayed on notice boards in churches and church halls. About a year later further appeals were made in magazines and booklets about the Project were displayed when clergy were circularised about the progress of the scheme. Also, following from the initial meetings with clergy, Project staff were put in touch with seven young wives groups. In each case when the group organiser had been approached, a field worker was invited to address the group as guest speaker. Usually an introductory talk about the experience of ageing was followed by some slides illustrating the statutory and voluntary services available to the elderly and others showing the work of the Project; then the Project would be described in some detail, the meeting would be given up to discussion, and visitors would be recruited. These meetings brought 17 people to join the Project as visitors. Similar talks at two church youth clubs also brought in five younger visitors. Later in the Project, staff arranged to speak to classes at an adult education centre situated in the area. The most satisfactory procedure evolved was to introduce a Project worker half way through lessons; he or she would then make a brief appeal to the class, and discuss details with any interested individuals and complete application forms. In this way two staff and a Project visitor were able to approach about six afternoon classes or six evening classes each day. The eight people recruited from the centre tended to be of higher social class than most visitors and a larger proportion lived outside the Project area.

Strong links were established with a teacher training college in another part of the city where Project staff spoke for one hour to a voluntary meeting of all first year students. There were also meetings with the student Social Service committee at the college and seven students undertook visiting through the Project.

Four other visitors were recruited from a local school following an address to the sixth form; five visitors were recruited at a party to sell plasticware; the remaining groups of various kinds which were approached did not produce any visitors. These included another local school, three community action groups whose members were already fully committed in various ways and two social clubs where brief appeals between bingo sessions fell upon stony ground.

Amongst all the groups described above, there were two where group members appeared amenable but their dominant group leaders adopted a defensive position as intermediary between the group and Project staff, and no visitors were forthcoming.

Posters and Postcards, etc.

From time to time these have been displayed in shops, launderettes and the waiting rooms of doctors, dentists and opticians practising in the Project area; postcards have been displayed in six newsagents. Although posters and postcards have on some occasions been displayed for many months, they are more usually removed within a month or two and it has proved worthwhile to renew the display from time to time. A typical poster runs "Have you ever wondered what happens to an elderly person when she comes home from hospital?" and continues to explain how visitors can sometimes help in this situation. In addition, half a dozen visitors were recruited through the printed church publicity referred to in the previous section.

Of the 23 visitors recruited in this way, only one was aged over 45: nearly half (10) were aged between 25 and 44, which is a rather higher proportion than for visitors recruited from any other source (one-fifth). It appears that advertising postcards is a relatively effective way of recruiting young adults, although total figures are small. Posters and postcards have also been effective in recruiting those visitors living within the Project area, where they have been displayed, only three of them lived outside this area.

Recruitment through Existing Visitors

These comprise the friends, colleagues and relatives of those already active in the Project, and who have shown an interest in visiting in a similar way. Young visitors were more often drawn into HEP this way: of the 19 people joining through existing visitors, 15 were under twenty five years old.

Recruitment through Personal Recommendation

No systematic drive has been made using this method of finding visitors, but from time to time people acquainted with the work of the Project have met others who have expressed an interest in such work. Amongst those to put people in touch with the Project in this way have been the staff of other voluntary agencies, Social Workers, Health Visitors and Medical Social Workers; working men, married women, school pupils and unemployed people have all come to the Project by this means.

Publicity in the Mass Media

The Project has received publicity through four articles printed in the local press, three appearances on local radio and one on Woman's Hour in the national BBC network; and a short appeal for visitors was placed in an advertising paper which is delivered to all households in the city. These resulted in a number of enquiries, most of them having little relevance to the actual work of the Project, and only two new visitors joined as a result of this publicity.

The remaining two visitors who joined on their own initiative were CSV's working at a local blind school who wished to take children out to visit elderly people nearby, and had found reference to

the Project in the telephone book.

The Approach towards Selection of Visitors

Spontaneous care of the elderly by friends and neighbours is seen to involve local people with all kinds of backgrounds, skills and temperaments. While qualities such as sensitivity, patience, resilience and determination may prove valuable assets in visiting the elderly, it has been felt that almost everyone has something he or she can contribute towards the welfare of an old person. Formal selection of visitors has therefore not been a policy of the Project, and referees have not been requested: however in cases of some doubt it has been possible to discuss an application with someone who knows the prospective visitor.

In practice, the introduction of a particular visitor to an elderly person depends upon the needs of the elderly person at that time, the proximity of the visitor's home and his or her availability, and the opinion of the Project staff on the suitability of the visitor for the elderly person and the envisaged responsibilities. These considerations lead to varying degrees of delay in the introduction of 'new' visitors to elderly people and provide scope for the deliberate non-use of visitors. In this way the introduction of three visitors about whom Project staff have reservations has been delayed indefinitely.

3.3 WHO DOES THE VISITING?

Although certain groups of people are found to visit and care for elderly people more than others, these responsibilities cannot be properly laid at the door of any one section of the community. Men and women, young and old all have different contributions to make to the care of old people. By drawing people together from all sections of the community out of a common concern for old people, the Health of the Elderly Project has hoped to make this fact clear to each visitor. The diverse resources made available to the Project in this way have enabled it to respond to a greater variety of needs. Gas fitters, electricians, professional hairdressers, student health visitors, medical students, and nurses are among those placing their skills at the disposal of the Project. A broad picture of the visitors can be obtained from Table 3A:

TABLE 3A: TYPOLOGY OF PROJECT VISITORS

Category (by precedence)	Female	Male	Total
Retired	4	1	5
Married women	41	-	41
Unemployed	3	3	6
Working full-time*	14	10	24
School pupils	13	4	17
College students**	16	2	18
	91	20	111

* i.e. excluding six who were married women

** excluding two who were married women.

The proportion of male volunteers is almost double that found by Shenfield (10%) in a study of 100 voluntary visitors of the elderly, but less than that found by the Institute of Community Studies (25%) in their survey of 114 volunteers engaged in various fields of voluntary work.

The age range of visitors is wide, as can be seen from Table 3B:

TABLE 3B : AGE OF PROJECT VISITORS

Age Group	Number of Visitors
15 - 19	25
20 - 24	31
25 - 34	16
35 - 44	12
45 - 54	17
55 - 64	6
Over 65	4
	111

The large numbers of younger people are only partly accounted for by college students and school pupils, as comparative studies show:

Study	Percentage of Visitors aged under 25
Institute of Community Studies	12
Shenfield - PEP	2
Manchester [1]	22
HEP - all visitors	50
HEP - excluding college students and school pupils from calculation	28

Related probably to this, a larger proportion of HEP visitors were single than in the PEP study, even when pupils and students were excluded:

	HEP* (%)	PEP (%)
Married	64	74
Widowed	4	10
Single/divorced/separated	32	16

* excluding students from calculations.

There were also smaller numbers of active elderly in the Proejct than in the other three surveys; this is no doubt partly because Project recruitment was directed at first towards those in the 18-30 age range, but it is possible that the young age of Project staff has dissuaded some of those over retirement age from joining the Project.

Other Activities amongst Visitors

Ninety Project visitors were asked whether they engaged in other organised activities. Forty-three of these mentioned no such activities, and many of these people may have been stepping into new areas of community involvement by joining the HEP organisation. Half of the remainder (20) referred to Wives groups and similar meetings, and adult education classes (seven), sports activities (seven) and youth activities (six) were three other common activities. As might be expected, visitors recruited from groups (including those accustomed to meeting regularly, and groups specially convened) were more likely to participate in other organised activities; 70% did

as compared to 38% amongst other visitors.

TABLE 3C : RESIDENCE AND ACTIVITIES OF PROJECT VISITORS, RELATED TO CATEGORY OF VISITOR

	Retired	Married women	Unemployed	Working full-time	School pupils	College students	TOTAL
Residence of Visitor:							
Within the Project area	5	30	4	18	11	5	73
In the wider west end	0	9	0	5	5	1	20
In other parts of city	0	2	2	1	1	12	18
Total	5	41	6	24	17	18	111
Activities with the Project:							
Number placed with elderly	5	34	5	16	13	15	88
Number subsequently completing questionnaires about their visiting	2	30	4	9	10	13	68
Frequency of Visiting:							
At lease twice a week	2	14	0	2	3	0	21
Once a week	0	15	4	6	6	13	44*
Activity Score: **							
More than 5	1	26	3	3	10	10	55
5 or less	1	4	1	6	0	3	15
Contact with Services and Appointments for Elderly:							
Some contact	1	12	0	1	2	3	19
No contact	1	18	4	8	8	10	49
Contact with Professional Workers for Elderly:							
Some contact	1	14	2	3	3	4	27
No contact	1	16	2	6	7	9	41
Contact with Neighbours & Relatives of Elderly concerning Specific Issues:							
Such contact	1	17	1	0	4	2	25
No such contact	1	13	3	9	6	11	43
Introductions made to Elderly People							
At least one	1	20	3	3	8	3	38
None	1	7	1	6	2	10	27***

* 3 others visited less than weekly

** See Section 4.2 for details

*** 3 others had taken a small child along with them while visiting.

When asked whether they helped to organise any such activities, 52 said no. A surprisingly large number - 18 - said they helped to organise activities for the young, including Guides, Brownies, Youth Clubs and the Junior Legion of Mary. Eight helped to organise Wives Groups, two men quoted Union activities, two students organised student groups, and others mentioned the running of luncheon clubs, the Hospital League of Friends, a Parent-Teacher Association and a WRVS meals on wheels service.

Forty-nine visitors attended church regularly, reflecting in part their sources of recruitment; and 40 said that they attended pubs or social clubs regularly. Asked about other experience of organised visiting of the elderly, 57 claimed none, 18 had done so in the past, and 15 were presently engaged in other organised visiting; check visiting of numbers of elderly through church schemes was the most common form of this to be mentioned.

The Categories of Visitors

The figures referred to in the following sections are rather small and interpretations placed upon them must remain tentative. MARRIED WOMEN constituted the largest group of visitors by far. The majority of these were housewives: only six had full-time jobs, and nine worked part-time. Of the 41 married women visiting, about one quarter had no children; six had a child under school age; and nearly half had children at school. Married women have proved to be particularly effective and natural visitors, as one might expect; as a group they have visited more often and had proportionately more live contact with the relatives, neighbours and friends of the elderly person they visit than any other group; and compared to other visitors as a whole, they have had proportionately more contact with services and with professional workers on behalf of the elderly people they visited through the Project, have introduced more people to them and have reached higher activity scores[2], although none of these trends reach levels of statistical significance.

Those 24 visitors who were WORKING FULL-TIME were less likely to be allocated to elderly people than other visitors: their limited availability restricted their potential scope in visiting situations, having only evenings and weekends in which to visit. They were also less likely to have questionnaires completed about their activities with the elderly owing to difficulties in arranging the necessary interview. Where questionnaires had been completed, they indicated that working visitors were the least likely to have significant contact with the friends, neighbours and relatives of the elderly, and reached lower activity scores than any other group of visitors. However, in other respects their activities were more comparable to those of other visitors, and a few instances have arisen of working visitors showing remarkable levels of commitment in view of the other demands upon their time.

Of those 18 COLLEGE STUDENTS who joined the Project, 12 did not live anywhere in the West End of the city, and these comprised two-thirds of all those Project visitors living outside the west end. This may partly account for the fact that of those 13 students questioned, none had visited an elderly person more than once a week, whereas two-thirds of all other visitors said they had done this. In most other respects, students were as effective in visiting as others were, except that they tended to introduce fewer friends and have less contact with an elderly person's relatives, friends and neighbours. Long vacations raise some difficulties in the use of students for regular visiting of the elderly; but many old people are at their most healthy in the summer months and they are unlikely to be as dependent upon weekly visitors as they are upon those who visit more often, so those whose student visitors disappear for the long vacation are not necessarily caused discomfort by this. This may also sometimes provide, in a least uncomfortable way, an opportunity for the relatives, neighbours and friends of an elderly person to take up a new practical role.

SCHOOL PUPILS have proved able visitors when placed with the right kind of elderly person, and the need for 'matching' in these cases is emphasised[3]. Some elderly folk love visits from young people, while others 'can't be bothered' with them. Questionnaires with ten pupils showed that some would sometimes bring their friends with them when they visited elderly people[4].

It is likely that those six UNEMPLOYED PEOPLE who joined the Project come from a wider range of backgrounds than one might expect in other parts of the country where unemployment is lower than in Newcastle. The only specific problem arising in this group is the likely discontinuation of visiting when full-time work is obtained.

The wish to draw in more RETIRED PEOPLE as Project visitors has been mentioned elsewhere and it is hoped that expansion may take place in this direction.

Visitors' Social Class

TABLE 3D : SOCIAL CLASS OF PROJECT VISITORS
(Registrar General's Classifications)

I	8
II	9
III Non manual	20
III Manual	18
IV	10
V	5
College students	18
School pupils	19**
TOTAL	107*

* no information on four visitors
** two of these had been unemployed since leaving school.

The organised visiting of the Project is not a noticeably middle-class passtime as has been said of some voluntary work: Project visitors have tended to be of lower social class than those interviewed in the studies by the Institute of Community Studies and by P.E.P.

The Residence of Visitors

The emphasis placed on finding as voluntary visitors people who live in the Project area has been stressed elsewhere. The following figures show the extent of success in this:

Of 111 visitors -

73 live within the Project area;
20 live in the wider west end of the city - normally a five to ten minutes' bus ride away;
18 live in other parts of the city.

The five areas[5] which fall within the Project boundaries have yielded differing numbers of visitors: 29 live in Benwell which is probably the most stable area of terraced housing; 14 live in Arthurs Hill and 13 in Elswick, the other two areas mainly of terraced houses and undergoing some redevelopment; 16 live in the residential area of lower Fenham; and just one visitor lives in the high rises of Cruddas Park. The failure to find visitors from the latter area has been unfortunate as many elderly people needing help live in these tall blocks of flats. A shortage of shops willing to display recruitment posters in the area can only partly explain this.

Visitors living within the Project area were found to visit elderly people more frequently, as is shown on Table 3E:

TABLE 3E : FREQUENCY OF VISITING RELATED TO AREA OF RESIDENCE

AREA OF RESIDENCE	TWO OR MORE DAYS WEEKLY	ONCE WEEKLY	TOTAL	
Within Project area	19	24	43	$\chi^2_2 = 9.2$
In outer West End	2	8	10	
Other parts of city	0	12	12	$p < 0.025$
TOTAL	21	44	65*	

* three other visitors called less than weekly.

While these figures may be biased by the large proportion of students amongst those visitors living in other parts of the city, these figures are in keeping with the assumption that those who live close to elderly people are likely to find it easier to call on them more frequently; this draws attention to the value of recruiting voluntary visitors from a localised area.

HEP visitors generally said they had called more often than those visitors in formal visiting schemes described in the PEP study:

FREQUENCY OF VISITING

	HEP %	PEP %
two-three days weekly	31	12
once weekly	65	35
less often	4	53
	n = 69	n = 75

The differences in frequency of visiting are no doubt partly explained by the fact that only 7% of active HEP visitors had visited more than two elderly people compared to 53% in the PEP study.

3.4 VISITORS AND THE ELDERLY PEOPLE IN THEIR LIVES

Some people who offer to visit elderly people through voluntary schemes have had considerable experience of such activities in the past as their own parents and other relatives have grown old, or as they have cared for elderly neighbours and friends. Others have never looked after old people in this way and are entering new areas of experience when they join an organised visiting scheme. 87 Health of the Elderly Project visitors have been interviewed about their involvement, past and present, with elderly people other than those known to them through the Project.

Just over half of those interviewed (45) said they presently visited old people other than the 'Project' elderly at least once a week, and 17 of these visited more than one such person every week. When asked whether they had visited any old people in the past at least once a week similar numbers (42) said they had and 21 had visited more than one person. One-quarter (19 visitors) claimed no experience of visiting an elderly person weekly outside the Project. Most of these were young people: although two were trainee Health Visitors and two were Medical

Students who had worked with large numbers of elderly people.

The length of commitment of visitors to these elderly people was then investigated. Visitors were asked to estimate how long they had known the elderly person, and for what length of time they had been visiting them at least once a week. Results were as follow: (the replies to similar questions about those visited weekly in the past are shown below the Table).

TABLE 3F : LENGTH OF COMMITMENT OF PROJECT VISITORS TO ELDERLY PEOPLE OUTSIDE THE PROJECT

	HOW LONG HAS HE/SHE BEEN VISITED WEEKLY?				
PRESENTLY BEING VISITED WEEKLY	Under 1 year	1 - 5 years	Over 5 years	Relatives, unable to say	
Length of acquaintance					
Under 1 year	4	-	-	-	
1 - 5 years	0	14	-	-	
Over 5 years	4	10	11	-	
Relative - unable to say	3	8	8	14	TOTAL
Presently being visited weekly - TOTAL	11	32	19	14	76*
VISITED WEEKLY IN PAST: TOTAL	24	34	15	4	77**

* 33 of those mentioned were in fact relatives.
** 25 of those mentioned were in fact relatives.

It is not possible to say how many visitors, if any, amongst those who have visited 110 elderly people weekly for less than one year, have been encouraged to increase their commitment in this way by their involvement with the Project - particularly as weekly visiting in the past had lasted under one year, for one-third of the elderly people quoted. Much past visiting had terminated with the death of the elderly person or their admission to an institution. The ageing relatives of visitors comprised 44% of all those who were being or had been visited at lease once a week by Project visitors. As might be expected, more married women and retired people (two-thirds) had visited old people in the past than other visitors.

Levels of Involvement

An attempt was made to measure the greatest level of commitment of each visitor with any of the elderly people whom they visited weekly outside the Project:

TABLE 3G : MAXIMUM LEVEL OF VISITORS' INVOLVEMENT WITH ELDERLY PEOPLE OUTSIDE THE PROJECT

	Present commitments	Past commitments
Personal and nursing care	1	11
Substantial practical help, such as cooking, lighting the fire, washing (including housemates not inc. above)	19	12
Help with messages - e.g. shopping, collecting pension - or occasional practical tasks	17	12
Companionship only - no practical role	8	7
TOTAL NUMBER VISITING WEEKLY	45	42

It had been common for help of a practical nature to be given within the spontaneous visiting of relatives, neighbours and friends by Project visitors.

It is noticeable also that with one exception those visitors who had provided personal care for an elderly person in the past were not doing so now. No doubt people presently bearing such responsibilities were unlikely to have time to offer themselves for voluntary visiting.

Contact with Professional Health and Social Service Staff on Behalf of the Elderly

87 Visitors were asked whether they had ever contacted a doctor, Health Visitor, Social Worker, Hospital Almoner or Hospital Sister on behalf of an elderly person:

40 said they had done so before joining the Project
18 others had done so only since joining the Project, usually on behalf of someone visited through the Project
the 29 other visitors said they had never done so.

Married women and retired people were most likely to have done this - over half of them had - and college students and school pupils were least likely - only one-fifth had done so. As to be expected, those visitors who claimed substantial past commitments with elderly people (c.f. the previous section) were more likely to have taken such action.

Contact with Services on Behalf of the Elderly

In the same way, visitors were asked whether they had ever contacted any services or made any appointments on behalf of elderly people:

27 had done so before joining the Project
20 others had done so only since joining the Project - most of these on behalf of an elderly person visited through the Project
and the remaining 39 had never taken such action.

Similar trends to those concerning contact with Health and Social Service Staff were evident, but they were not so marked.

The fact that one-quarter of those visitors interviewed had their first contact concerning services or appointments on behalf of the elderly since joining the Project, and that one-fifth had their first contact with Health and Social Service Staff on behalf of the elderly since this time, seems relevant to discussion on voluntary visiting as a means of social education.

3.5 THE ATTITUDES OF VISITORS

Visitors' Perception of their Work

Visitors were asked which of the following two statements they felt to be nearer the truth:

(a) I have not done anything through HEP which I would not have done anyway if I had known about that person in need. What the Project has done is to tell me about that person and how I could help.

or (b) HEP has led me to discover ways of helping people which I would not otherwise have thought of: it has enabled me to do things which it would not have occurred to me to do.

Some 60% of visitors interviewed chose answer (a) and this proportion proved remarkably similar for each category of visitor:

TABLE 3H : VISITORS PERCEPTION OF THEIR WORK: THE 'NEAREST THE TRUTH' QUESTION RELATED TO CHARACTERISTICS OF VISITORS

	(a)	(b)
TOTAL NUMBER OF VISITORS	47	31
AGE OF VISITOR:		
15 - 19 years	6	9
20 - 44 years	25	17
45+	16	5
CONTACT WITH SERVICES ON BEHALF OF OLD PEOPLE:		
Before joining the Project	20	6
Only since joining	12	8
No contact	15	16
CONTACT WITH PROFESSIONALS ON BEHALF OF OLD PEOPLE:		
Before joining the Project	23	11
Only since joining	11	6
No contact	13	14
CONTACT WITH NEIGHBOURS ON BEHALF OF OLD PEOPLE:		
Contact with neighbour of Project elderly for specific purpose	18	7
No such contact	19	19

However, older visitors were more likely to choose (a) than younger visitors. Of those visitors who had made contacts of various kinds on behalf of elderly people, in each case over two-thirds chose (a): of the remainder answers were split evenly between the two possibilities, suggesting a random response.

There were no noticeable relationships between the answers to this question and the various measures of visitors 'activity level' in the Project, nor with their past experiences with the elderly.

Possible Levels of Commitment

Imagine that an elderly person were to live very close to a Project visitor: someone whom the visitor already knew, and who needed help with getting up and dressing every morning, and who needed breakfast, lunch and dinner to be prepared for her, shopping to be done, and needed putting to bed and locking up at night. Given the present commitments of the visitor, how often would he or she be able to visit that elderly person? This, albeit hypothetical, question was asked of Project visitors in order to gauge their likely response in an 'ideal' neighbourly care situation:

TABLE 3I: POSSIBLE LEVELS OF COMMITMENT BY PROJECT VISITORS

More than twice daily	6
Twice daily	18
Once daily	36
Several days weekly	21
Less often or impossible	6
TOTAL	87

Women generally felt more able to visit at least once every day than did men; those already visiting other elderly people felt able to visit more often than those not doing this - perhaps reflecting commitments which had discouraged the latter from visiting other elderly. Alternatively, this may suggest that commitment is a question of attitudes: those who have the greatest inclination to visit elderly people 'spontaneously' are also those most ready to undertake greater responsibilities on their behalf.

No other significant relationships were detected between answers to this question and others.

TABLE 3J: POSSIBLE LEVELS OF COMMITMENT BY PROJECT VISITORS RELATED TO CERTAIN CHARACTERISTICS OF VISITORS

	Twice daily or more	Daily	Less often
SEX: Men	4	2	7
Women	20	34	18
SOCIAL ACTIVITIES:			
Engaging in social activities	13	14	17
No such activities	11	21	8
NUMBER OF ELDERLY BEING VISITED OUTSIDE PROJECT:			
One or more	16	17	11
None	8	18	14

Neighbourly Activities and Statutory Provision

There are some things which one can reasonably expect good neighbours and friends of the elderly to do for them; in other areas of need it may be appropriate for the state to accept responsibility and provide personnel and materials to meet those needs. 87 visitors were asked to say into which of these two categories certain activities fell. It was pointed out that this was not to ask "Should the state spend its money on getting this done?" but "How should the state spend its money on getting this done?", the state might pay a voluntary organisation to recruit neighbours to do things in the first category, whereas in the latter case it might employ people to undertake the tasks. Relatives were omitted from consideration as this would complicate the issue and they are not directly accessible through voluntary organisations in the way that neighbours are.

(i) 'Reasonable' tasks - neighbours, and friends of the elderly can be expected to perform the following in the opinion of over three-quarters of visitors:

'Ongoing' tasks	Percentage considering this reasonable	'Once-off' tasks	Percentage considering this reasonable
Shopping	100	Escorting on a shopping trip into town	99
Making the fire	99	Providing transport to visit relatives in hospital	86
Collecting the pension	95	Visiting daily while a neighbour who usually helps is on holiday	84
'Supervising'*	95	Help with packing prior to removal	84
Pushing out in a wheelchair	94		
Cooking meals	86		
Ensuring she takes medicines	82		
Washing clothes	76		

* sitting with an incapacitated old person to allow his or her housemate to go out.

(ii) 'Doubtful' tasks - those about which visitors as a whole expressed uncertainty. Between one-quarter and three-quarters of visitors considered these tasks unreasonable:

'Ongoing' tasks	Percentage considering this reasonable	'Once-off' tasks	Percentage considering this reasonable
Helping at the toilet	70	Transport to appointments	72
Arranging services	70	Giving a home perm	70
Dressing	67	Decorating a room	70
Housework	25	Laying lino	67
		Cutting hair	56
		Clearing up an overgrown garden	49
		Negotiations for a grant from the Dept. of Health & Social Security	48

(iii) 'Unreasonable' tasks - less than one-quarter of visitors interviewed considered it reasonable for friends and neighbours to do the following:

'Ongoing' tasks	Percentage considering this reasonable	'Once-off' tasks	Percentage considering this reasonable
Applying medicaments	17	Clearing out a filthy house	15
Giving a bath	7		

Amongst those tasks considered unreasonable for friends or neighbours by a substantial proportion of visitors, some are already undertaken by statutory services: Bath Attendants bath elderly people, District Nurses apply medicaments, Home Helps do housework and where operative a Home Help 'Dirty Squad' may clean out a filthy house. The opinion of visitors suggests that there is a place for a domiciliary hairdressing service: perhaps a hairdresser could be subsidised by Social Services on a 'per capita' basis to undertake this kind of work with its inevitably slower

remuneration and greater expenditure of effort. Similarly, visitors' attitudes point to the possible need for a statutory gardening service of the kind presently being set up in Wandsworth, London.

In view of the encouragement given to Project visitors to contact statutory bodies on behalf of the elderly, it is rather surprising that over half of those interviewed did not feel that neighbours should be expected to negotiate for a grant from the Department of Health and Social Security for an elderly person, and nearly one-third did not feel they should be expected to arrange statutory services. If this attitude is representative of those likely to care for the elderly, it suggests that education in welfare rights needs to be taken much further than has so far been the case. In addition to this there may be a need for a more systematic assessment of all elderly people for the basic provisions of Home Help, Meals on Wheels, specific benefits, Chiropody, Bath Attendant, Dresser and Optical and Hearing Aid services. This would seem to constitute a natural part of the preventive work of the Health Visitor Service, with its potential for development[6].

The Variations in Attitude

Those 87 visitors who had answered these questions were each attributed a score for the number of ongoing tasks they felt neighbours could do, and a similar score relating to 'once-off' jobs. Differences emerged between the attitudes of visitors:

TABLE 3K : RELATIONSHIP BETWEEN CATEGORY OF VISITOR AND NUMBER OF ONGOING TASKS CONSIDERED REASONABLE

	SCORE (Max=14)		
	High (9+)	Low (8-)	
School pupils and college students	24	3	$\chi^2_2 = 8.74$
Married women, retired and unemployed	32	10	
Working full-time	9	9	$p < 0.025$

Young people tended to feel that neighbours should do more - perhaps revealing a youthful idealism - while those who worked full-time had the greatest reservations about neighbourly commitments, reflecting no doubt their own busy lives. However, similar trends were not apparent for the 'once-off' job score. No other trends were apparent.

The 'once-off' job score showed one distinct relationship with the level of past commitment of visitors:

TABLE 3L : NUMBER OF 'ONCE-OFF' TASKS CONSIDERED REASONABLE RELATED TO VISITORS' PAST EXPERIENCE WITH THE ELDERLY

EXTENT OF PAST COMMITMENT	ONCE-OFF SCORE (Max=12)		
	High (8+)	Low (7-)	
'Substantial' past commitment	8	14	$\chi^2_2 = 12.2$
Help with messages or friendly visiting only	17	2	$p < 0.005$
No weekly visiting of elderly in the past	28	17	

Those with considerable past experience of looking after elderly people generally thought neighbours could undertake less once-off tasks, while those with definite, but more limited experience in this field were the most ready to expect tasks of neighbours.

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1. A survey conducted in 1967 by Manchester and Salford Council of Social Service, and Manchester Youth and Community Service, into the preparation and training of voluntary workers in Manchester by 77 statutory and voluntary bodies.
2. c.f. Section 4.2, p.
3. See Section 4.2.
4. The contribution of younger visitors is described in 'Task Force', by Tim Dartington.
5. See p. (Section 1.2).
6. See for example, Williamson, Lowther & Grey (1966).

SUMMARY - CHAPTER 3 THE PROJECT VISITORS

The Project aimed to spark off voluntary care which would be of similar quality to that often provided by relatives, friends and neighbours of the elderly. To enable this Project visitors were sought from the local area; they were asked to visit just one or perhaps two old people living close to them and to undertake reasonable practical tasks such as escorting to the shops, cooking, shopping and providing regular transport to visit friends and relatives.

Of the visitors to join the Project in the first fifteen months, over one-third were married women; there were also college students, school pupils, men and women in full-time work, unemployed people and active pensioners: twenty visitors were men. Most visitors had been recruited from meetings such as young wives groups by Project staff, through posters and postcards displayed in local shops, through existing Project visitors or through the recommendation of people acquainted with the work of the Project. Altogether, personal contact accounted for the recruitment of three-quarters of visitors. Their backgrounds were varied: half the adult visitors were of Social Class III, one-quarter were of Classes I and II and one-quarter were of Classes IV and V.

Two-thirds of visitors lived within the Project area, and these were found to visit the old people they had been introduced to more frequently than did those living outside the Project area. Almost all the visitors questioned had visited at least once weekly, and one-third usually called on two or more days of the week.

By various measures married women were slightly more effective as visitors than other people; students were as effective in most respects as other visitors, except that none visited more than once weekly - probably because two-thirds of them lived outside the Project area.

Of 87 visitors interviewed, many had experience with elderly people outside the Project. Only one-quarter claimed never to have visited an old person weekly other than through the Project, and most of these were young people. Half the visitors said they were presently calling every week on old people outside the Project, including many elderly relatives. Nearly half had contacted professional Health and Social Services staff on behalf of an elderly person before joining the Project, and one-third had contacted state services for this purpose (a further quarter of the visitors had done each of these things for the first time since joining the Project).

Opinions were sought from the same visitors on the tasks appropriate to neighbours of the old and to state services. Presented with a list of ongoing tasks, students and school pupils stood out from other visitors as expecting more of neighbours; discussion on a similar list of 'once-off' tasks showed that visitors with substantial past commitments to old people were more demanding of state services than were other visitors.

CHAPTER FOUR

VISTORS IN ACTION

4.1 THE ORGANISATION OF VISITING

One might describe the Health of the Elderly Project as providing a channel of communication which enables neighbourly help to happen. However, in the organisation of this help, opportunities also arise to influence its nature. New visitors are briefed; meetings for all visitors are held; elderly people referred to the Project are assessed by field staff who select appropriate visitors, and then discuss the situation with them and subsequently field staff keep in touch with active visitors to support them.

Briefing New Visitors

Over the period of 18 months from November 1972 an average of 6 new people have offered to visit through the Health of the Elderly Project each month. Whenever a total of about a dozen of these 'new' visitors have joined, they are invited to a group briefing session. Of 111 such people, 57 have been briefed in this way: experience has shown that the remainder, who have failed to respond to two successive invitations to briefing sessions, are unlikely to respond to further invitation. It is not clear whether the lack of response from nearly half the Project visitors arises from an aversion to meetings in general, or from a scepticism about the value of briefing in particular. It is however noticeable that those people who have already started visiting through the Project respond better than those still awaiting introduction to an elderly person.

Briefing sessions fulfill a two-fold purpose: firstly, stimulating visitors into a deeper perception of the psychological, social and physical aspects of old age and assisting them in developing the personal skills necessary to act upon this; and secondly, providing practical information concerning services available to the elderly and insight into their significance for old people, in order that visitors may have the knowledge to act effectively. Sessions take the form of a one-hour evening meeting: these usually start with discussion on the work of the Project, drawing upon the experience of individuals present in order to illustrate various points; visitors are then given leaflets which provide information on the services available to the elderly and the steps necessary to obtain them.

Meetings for all Visitors

These have been arranged at intervals of several months to pursue further those aims of briefing outlined above. Guest speakers have been a Consultant Geriatrician, a General Practitioner, a Social Worker and Health Visitors who showed a film on Health Visiting, each discussing the problems of old age and describing their own work with the elderly; a film 'The Whisperers', held in the lecture theatre of the General Hospital was followed by a talk on Community Care by the Organising Secretary of Age Concern Newcastle; and a wine and cheese party was held after one year of work, drawing together professional workers and Project visitors.

As with briefing sessions, the response to these meetings has been rather disappointing - an average of one in six of those invited have attended on each occasion. As one visitor put it: "I joined the Project to visit someone old and I'm not interested in meetings", and this may be a fairly common attitude amongst local people.

Assessment of Need

Every elderly person referred to the Project is visited by a staff member who decides whether it is appropriate to place a Project visitor. This decision takes into account the importance of the need indicated by the referrer, the possible alternative and more suitable sources of help - including both statutory services and friends, neighbours and relatives - and the attitude of the elderly person to a suggested course of action. It is not unusual for an assessment visit to last an hour, and the skills required in taking such a 'case history' should not be underestimated[1].

Matching and Placing Visitors

Project staff are able to estimate from an assessment visit the difficulties which a Project visitor may have to face, and pick the kind of visitor likely to be most effective. The situation may make no special demands; on the other hand it may require a particularly sensitive visitor, or a strong personality capable of a little 'friendly bullying' or a school pupil who can fulfill the role of a grandchild.

The choice of a visitor also takes into account the times when he or she will be available and, especially important, the distance of his or her home from the elderly person. With a dense distribution of visitors in an area of $1\frac{1}{2}$ square miles, it has often been possible to arrange a visitor who lives within a few minutes walk or shops close by the elderly person's home: in fact there have been 4 cases where visitors have been introduced to elderly people they happened to know slightly from the past - one through having used the same shops, one from past church contact, one from having worked adjacent allotments.

It has been possible to maintain a pool of about twenty visitors 'on standby' at any given time; when a situation arises which demands a new visitor, one of these is approached and the situation and envisaged commitment is outlined. If the visitor is agreeable, the Project worker arranges to introduce the visitor personally to the elderly person: in this way the problem of a stranger at the door is overcome.

Supporting the Visitor

When a local person has started visiting an elderly person regularly, the Project worker involved usually calls upon the visitor about once every two months to discuss developments. Both this contact and the briefing referred to above aim to develop and maintain a sensitive perception of the elderly contact's felt and observed needs, and of the visitor's own involvement; to encourage a broad view of the elderly contact's situation, enabling the visitor to locate his or her activities within the context of other help; and to help the visitor to come to terms with any difficulties arising, for example, from personality traits of the elderly contact.

The most obvious illustrations of this support emerge from crises. 11 visitors have experienced the death of their elderly friend and support has been given at this time, particularly when the visitor has been young. In one case a lady of 88 had a stroke while being driven out by her visitor; another very emaciated lady was sick after eating (perfectly wholesome!) food prepared by a visitor: in both cases the visitor concerned was caused considerable distress and re-assurance was needed.

Visitors are also encouraged to contact Project staff for advice and to report developments, but for normal purposes meeting visitors in their own homes has proved the most effective method of communication[2].

4.2 VISITORS IN ACTION

In order to obtain information on the activities performed for the elderly people by Project visitors, questionnaires were completed by visitors for 80 of those 91 old people with whom they were placed to give ongoing help[3]. In the remaining 11 cases, involvement turned out to be minimal: one person dies and three others entered institutions within a few weeks of being first visited; three people changed their minds about proposed arrangements; in three cases the arrangements turned out to be inappropriate, and in one case an elderly man's large alsatian chased his young visitor up a tree and he discontinued visiting.

Frequency of Usual Visiting

Amongst the above 80 elderly people, five were visited less than weekly by their HEP visitor; 47 were visited weekly; and the remaining 28 were visited on two or three days every week. The latter figure seems encouraging, particularly as in a number of these cases it had only been suggested to visitors that they call once weekly.

As crises occur, one might hope that visitors could respond by visiting more regularly. In fact, the visitors of 15 people said they had done this:

On 4 occasions this was the period following hospital discharge;
On 3 occasions it was a period of illness;
On 2 occasions a visitor was attending to a special problem;
On 2 occasions the gas crisis was referred to;
On 5 occasions the elderly person was visited in hospital;
and on 1 occasion the elderly person had been bereaved.

During the above periods:

3 people were visited daily
5 people were visited 4 - 6 days weekly
6 people were visited 2 - 3 days weekly
1 person was visited weekly.

A heartwarming example of a visitor's response to crisis is that of Mrs. B. who used to visit an elderly spinster and brother. When the old lady died, Mrs. B. took her brother into her own home for a week, during which time she made all the funeral arrangements - she and another HEP visitor were the only guests at the funeral - and he responded well to the interest of Mrs. B., her husband and children, who accepted him as one of the family.

Activities Undertaken by Visitors

Project visitors often become involved with an elderly person with a quite specific anticipated role, such as shopping on a day that the Home Help doesn't come. However, they naturally respond to a variety of other needs as the occasion arises, and in order to measure this Project visitors were presented with a list of activities and asked to tick those which they had performed for the elderly person in question; later they were asked to indicate which of these have been performed regularly. The following activities had been undertaken on behalf of at least 5 of the 80 people:

TABLE 4A : 32 ACTIVITIES PERFORMED BY PROJECT VISITORS WITH THE PROJECT ELDERLY

	No. of elderly on whose behalf this activity was performed regularly	No. of elderly on whose behalf this activity has ever been performed
Visited in hospital	9	20
Visited while on convalescence or in residential care	0	12
Visited on Xmas day	0*	12
Taken elderly person into own home	0	7
Within the house:		
Made a cup of tea	29	43
Washed up dishes	24	37
Taken a present of food	12	31
Cooked a meal	14	23
Brought coals in	15	20
Opened tins of food	8	17
Taken a meal from own home	9	16
Done light housework	4	15
Lit the fire	4	11
Taken washing home to do	0	5
Washed and set hair	0	5
Escorting and driving:		
Escorted to shops	4	7
Driven to visit relatives in hospital	3	7
Driven to visit friends or relatives at home	2	6
Driven to shops	2	6
Escorted to an appointment	1	6
Messages:		
Shopping	34	54
Bought a special item	7	26
Collected a prescription	3	14
Collected a pension	5	13
Taken washing to launderette	3	5
Reading and writing:		
Sent her an Xmas card	0*	39
Taken books or magazines	9	21
Read a letter out loud	3	20
Written to her when unable to visit	0	18
Written a letter for her	2	11
Collected library books	5	6
Read a book out loud	0	6

* not applicable

It is apparent that Project visitors have been able to engage in a wide range of activities with their elderly friends, many of these unforeseen before visiting commenced. The most common activities are not necessarily the most important: it is perhaps more important that visitors had taken seven old people into their own homes than that 39 old people had been sent Christmas cards.

Forth-three percent of all activities had been done regularly; some of the others, such as visiting on Christmas day, were occasional by nature; otherwise it is likely that the activities were usually performed by the elderly person or her relatives, neighbours and friends, or by statutory services, and only occasionally needed the assistance of visitors. Although the performance of these tasks would rarely be crucial to the elderly person's wellbeing, they would relieve the various lesser restrictions imposed by old age and dependency, and were considered an important part of the Project's work.

In order to study the distribution of visitors' activities amongst elderly people, each elderly person was ascribed a 'visitor activity score', obtained by calculating the total number of different listed activities undertaken by HEP visitors on his or her behalf:

TABLE 4B : THE NUMBER OF SELECTED ACTIVITIES UNDERTAKEN BY PROJECT VISITORS ON BEHALF OF 80 OLD PEOPLE

NUMBER OF ACTIVITIES UNDERTAKEN	NUMBER OF ELDERLY PEOPLE
0 - 4	26
5 - 9	34
10 - 14	13
15 - 19	5
20 - 24	2
	80

Only four elderly people had nothing practical done on their behalf: more usually visitors had responded to quite a variety of needs, and in some cases a large number. Sometimes a low score conceals a specific but important visitor's role: in one case a housebound lady was driven each week to lunch with her brother and his wife; two other ladies were taken to visit relatives in long-stay hospital; one chairfast lady was kept company so that her husband could go out shopping; another lady was pushed out in her wheelchair to do shopping each week; and a gentleman rendered dumb and housebound by a stroke had played over 100 games of chess with a lad who is captain of his school chess team.

Visitors' Contact with Statutory Services and with Professional Workers

Having been briefed on those services available to the elderly, visitors might be expected to discern the need for one of the statutory services from time to time, or to make the occasional enquiry concerning a service already being provided. Contact between visitors and services on behalf of 80 elderly people had been as follows:[4]

TABLE 4C : SERVICES CONTACTED BY PROJECT VISITORS ON BEHALF OF 80 OLD PEOPLE

SERVICE CONTACTED	NUMBER OF ELDERLY
More than one service	10
Home Help	1
Meals on Wheels	7
Bath Attendant	2
Chiropody	1
Housebound readers library service	2
	23

Amongst those on whose behalf a service has been contacted, nearly half were put in touch with more than one service: this may mean that those with service inadequacies or other difficulties are likely to have such troubles with services in general. An example of this group was a lady developing a cataract and on whose behalf a visitor requested, and was granted, an increase in Home Help hours from twice weekly to five days weekly, in order to light her coal fire each morning: the same visitor arranged chiropody for her, and later Meals on Wheels when the neighbour who usually cooked her lunch left Newcastle to stay with a daughter for several months. Eleven requests were for a new service (this figure includes requests made in the first instance by visitors to Project staff, although in such cases staff have usually advised visitors to take the appropriate action). Of the remaining twelve queries, eleven were either requests for an increase in the level of a service, or queries concerning the resumption of a discontinued service. Sometimes the reasons for withdrawal of a service were not clear to an elderly person; delay in reallocating a service following hospital discharge was one recurrent problem.

In addition, the visitors of nine elderly people had made contacts relating to appointments at Hospital Out-patients Departments, Opticians appointments, one was to request an ambulance for an appointment which had already been arranged, one was to inform the ambulance depot of a patient's change of address, one was to confirm an uncertain appointment, and the remaining contact, included with doubtful justification in this section, refers to an elderly gent who fell at home and broke his wrist, and his visitor found him and escorted him to casualty department where treatment was arranged.

In a Project which sets out to get local people working hand in hand with professional workers in a mutual concern for elderly people, direct contact between these two groups may be attributed some value, whatever its nature. The visitors of one-third of the elderly people had been in touch with professional workers on their behalf:

TABLE 4D : PROFESSIONAL WORKERS CONTACTED BY PROJECT VISITORS ON BEHALF OF 80 OLD PEOPLE

PROFESSIONAL WORKERS CONTACTED	NUMBER OF OLD PEOPLE
More than one	14
General Practitioner only	5
Health Visitor only	2
Social Worker only	1
Medical Social Worker only	1
Hospital Sister only	2

As with services, those put in touch with a professional worker were usually put in touch with more than one - perhaps illustrating the manner in which the personal needs of the elderly cut across present boundaries of statutory responsibility. One visitor had also contacted the Council concerning repairs to a house; another had put an elderly ex-policeman in touch with the Police Benevolent Society; a dentist, a councillor, a solicitor, the Public Health Inspector, the Housing Department, the Matron of a Residential Home, the Gas and Electricity Boards, TV rental agencies and various other professional and commercial agencies have all been contacted by visitors at different times.

Visitors' Contact with the Friends, Neighbours and Relatives of the Elderly

Early in the Project, it was postulated that organised visitors would be instrumental in deepening the commitment of relatives, friends and neighbours towards elderly people, by demonstrating practical roles as plausible, by mediating on behalf of an elderly person and by giving direct encouragement. A pre-requisite of this happening, though not a guarantee of it, must be contact between Project visitors and these people.

Visitors of nearly half the elderly people (38) had met a relative of that person[5]; friends, neighbours and relatives were then considered together with the following results:

TABLE 4E : NUMBER OF FRIENDS, NEIGHBOURS AND RELATIVES OF 80 OLD PEOPLE ENCOUNTERED BY PROJECT VISITORS

NUMBER OF FRIENDS, NEIGHBOURS AND RELATIVES CONTACTED	NUMBER OF OLD PEOPLE
None	20
Housemate only	4
1	19
2	21
3	7
4 or more	9

Altogether the visitors of 56 elderly had been in contact with at least one friend, neighbour or relative of an old person. Of these 56 records of contact between HEP visitors and others, 26 were related to a specific purpose; another five were limited to consultation with neighbours when a visitor was unable to get a reply; and the remaining 25 were purely 'social' encounters, usually within the elderly person's home. The 26 'deliberate' encounters recorded were diverse in nature. There were examples of elderly people asking Project visitors to contact their friends with messages and with requests that they call; other HEP visitors asked neighbours to do shopping, asked them to call when the elderly person was ill, or informed them of the old person's admission to hospital, amongst other things. With eight elderly, instances were recorded of friends, neighbours and relatives initiating contact with HEP visitors, for example when the elderly person has fallen ill.

Other People Introduced by Visitors

"Did you know you're the tip of an iceberg?" began one item in a newsletter to visitors; it went on to outline the part visitors can play in sparking off new friendships by introducing their own friends and family to the elderly person whom they visit. Over half (42) of those for whom questionnaires were completed had been introduced to someone new through their HEP visitors; of the remaining 38 elderly people, four had met the young child of a HEP visitor - an experience which some would enjoy very much - and the others had made no new acquaintances in this way.

TABLE 4F : NUMBER OF PEOPLE INTRODUCED BY PROJECT VISITORS TO 80 OLD PEOPLE

NUMBER OF PEOPLE INTRODUCED	NUMBER OF OLD PEOPLE
0	34
a child only	4
1	20
2	13
3	6
4 or more	3
	80

For 19 of the 42 people introduced to someone new, this was limited to occasions when HEP visitors brought with them a friend or one of the family - in some cases regularly, in other cases on one or two visits. 13 others received help with a specific task from their new acquaintance: for example, a number provided transport for the elderly person, several visitors' husbands did household repairs, others delivered large items including a TV and furniture, and the children of a few visitors had run messages. The nine remaining elderly people were visited regularly and independently by their new friend. An example is provided by Marion, a student, visiting Mrs. T., who took a summer job at a local hospital, during which time she visited the old lady in her dinner hour and regularly took a work colleague, Rachael, with her. Since Marion left her job and returned to study, Rachael has continued to visit Mrs. T. each week.

4.3 THE EVALUATION OF ORGANISED VISITING

The Follow-up Questionnaire to Elderly People

During a period from May 1972 until January 1973, 50 questionnaires were completed with elderly people for whom regular visitors had been arranged. In April 1973 a further short questionnaire was completed with those 40 who remained in the community at that time, in order to measure changes in certain areas of their life.[7] Again, the extent to which a visitor's involvement has been a contributory factor in producing these changes or in meeting needs can sometimes only be postulated. In some cases, referral to the Project has been one of several steps following from a new awareness amongst professional workers of the needs of a particular elderly individual: sometimes this awareness itself has been induced by distinct developments in that person's life. There may be various pressures for change and it is sometimes not possible to unravel the contribution of an organised visitor in this process. For instance, it is difficult to tell whether, if the visitor had not fulfilled a certain need, it would have somehow been met in another way.

Provision of Statutory Services

TABLE 4G : CHANGES IN THE PROVISION OF SERVICES TO 40 ELDERLY PEOPLE ON FOLLOW-UP

	Home Help	Meals on Wheels	Bath Attendant	Chiropody	Housebound Readers Library Service	TOTAL
Service newly arranged	1	5	6	3	7	22
Increase in level of provision	6	2	0	0	0	8
No change	28	28	34	37	33	160
Temporary decrease in or withdrawl of provision	1	4*	0	0	0	5
Decrease in level of provision	4**	0	0	0	0	4
Service discontinued	0	1	0	0	0	1
TOTAL	40	40	40	40	40	

* arising from delays in reallocation following a stay in hospital or rehousing.

** apparently caused by redeployment of services.

Of the 22 new services being provided, 11 were arranged directly by the Project (although 7 of these were for the Housebound Readers library service). Nine were arranged by professional workers - 2 of those at the request of the Project, attempting to encourage a Professional Worker in his responsibilities rather than relieve him of them. A relative and a friend arranged the remaining two new services.

Patterns of Visiting by Relatives, Friends and Neighbours

Of 161 relatives, friends and neighbours who were originally recorded as visiting these 40 elderly people each week, 12 had ceased visiting on follow-up. Four of these had moved out of the area, four had ceased calling since the elderly person had been rehoused, and three had been prevented from continuing to visit by the onset of illness; no explanation was given for the other visitor. In these ways, ten elderly people had lost one visitor, and one had lost two.

On the other side of the coin, 18 people had new weekly visitors: this figure includes people who were originally visiting less often than weekly and now visited more often. Relatives had started visiting weekly in five cases, as had friends and neighbours in the other 13 cases. Taking account of other causes for these increases in commitment, and allowing for errors in information - the difficulties in obtaining accurate details of those who visit the elderly has been referred to elsewhere, and visitors overlooked in the original questionnaire may have been brought to light in the follow-up - Project staff are led to propose tentatively that organised visitors, by demonstrating a responsible and caring relationship, can prompt relatives and others to respond more fully to the needs of elderly people (without necessarily asking them to do so explicitly).

Social Activities

The follow-up questionnaire revealed that six of those not previously participating in organised social activities were now attending luncheon clubs, Over-60 clubs, Day care or some similar group function. Only two of these can be related with any certainty to the activities of Project

visitors: one was a lady who was introduced to a luncheon club which she had since regularly attended; the other was a very depressed lady in her sixties whose visitor introduced her to the Matron of a nearby Residential Home and encouraged her to call there regularly to chat with the residents. She did this and was soon helping to serve tea and assisting residents to the toilet.

4.4 THE BUGBEARS OF VOLUNTARY WORK

There are certain unflattering cliches about voluntary work which are heard from time to time, particularly in conversation with people who have limited personal experience of working with volunteers[8]. Three such 'problem areas' are as follows:

Confidentiality

"Aren't old people scared that their volunteers will gossip about their private affairs?" No cases of distress caused to elderly people through gossiping visitors have come to the notice of Project staff. It is proposed that amongst the large numbers of elderly people who are cared for by neighbours and friends, gossip is not a major destructive force, and there is no reason to expect any difference amongst organised visitors if they have similar caring motives and are able to establish comparable relationships with the elderly.

Problems of confidentiality arise more in the flow of information between professional workers, Project staff and visitors. How much should professional workers tell Project staff about an elderly person, and vice-versa? And then how much should staff tell Project visitors, and vice-versa? One might imagine an elderly person being upset to learn that her visitor was aware of a certain piece of personal information which she had disclosed only to her doctor or Health Visitor. Information also flows from visitors to professional workers via Project staff and this could also raise ethical problems. On a number of occasions professional workers have been helped in their assessment of a situation by the presentation of a more accurate picture of events than he or she has been able to obtain, or is likely to obtain, directly from the elderly person. On one such occasion a hospital specialist was advised of an old lady's secret drinking habits prior to her out-patient appointment: unfortunately the doctor asked her about this in too direct a manner for she was very indignant later that he must have been told about them, thus illustrating the kinds of difficulties which can arise.

No detailed guidelines are suggested here: but one sound precaution would be for the staff of visiting projects to request and to respect the opinion of visitors and of professional staff whether to pass on doubtful information from one to the other or to with-hold it. Further thinking upon this topic might draw fruitfully upon the recent codes proposed by the Medical Research Council.

Unreliability and Accountability

"Don't you find that volunteers often let you down - do you carry the can when this happens?" A satisfactory index of unreliability would probably have to take into account the frequency with which undertakings had not been adhered to; the significance of each of these occasions; and whether any notification or explanation had been given by the visitor.

Probably the most usual examples of unreliability are when a visitor fails to perform a specific task at a pre-arranged time, or when he fails to visit on an agreed day, without prior warning. The number of such occurrences coming to the notice of Project staff has been quite small: whereas 19 visitors claim to have written to warn the elderly friends when they were unable to call, and a number of others have sent one of the family in their place. Such steps have been encouraged in the briefing of visitors: also stressed in briefing is the importance of informing

Project staff if a visitor ceases visiting a particular person regularly. From 91 active visitors, seven have been recorded as failing to do this. It is always possible that an instance of a visitor's unreliability may have unexpectedly distressing effects, and the organisers of a visiting scheme must accept a responsibility to avoid such events. However, the absence of any legally binding obligations in this area of work preclude an enforceable system of accountability: neighbours, 'organised' or otherwise, are not infallible and perhaps the consequences of this have to be accepted as an inevitable aspect of true community care.

Discontinuity and Drop-outs

"Do your volunteers stay with you very long - don't they soon lose interest?" Out of 111 visitors who have been with the Health of the Elderly Project for an average of 8 months, 91 are still with the Project, and 20 have left:

TABLE 4H : 111 PROJECT VISITORS ON FOLLOW-UP

Still visiting	91
Moved out of the area	10
Taken a full-time job	2
Pressure of studies	2
New family commitments	3
Other spare-time commitments	2
Untraceable	1
	111

It is predictable that 'loss of interest' was never given by a visitor as a reason for leaving the Project, but it is estimated that this was a likely factor for 3 or 4 of those leaving. There have been after all sometimes comparable pressures upon the 91 visitors who have nevertheless retained their involvement with the Project: of these, three have moved out of the area; two have taken full-time jobs and three have taken part-time jobs; five others have left school and taken jobs; three have given birth to a new child and one has married. Three students who had finished their courses were amongst the 13 visitors leaving the area; but this second figure is still high and is no doubt associated with the amount of redevelopment taking place in the area.

The fact that seven visitors (not including student/school leavers) have taken full-time or part-time jobs suggests that some of those who offer to visit through the Project are looking quite firmly for ways of filling spare time which they have.

If a person leaves the Project and has been visiting an elderly person up to that point, Project staff may decide to introduce a new visitor in his or her place. This has been done on nine occasions, but is considered unfortunate. It is to be hoped that as 'organised' visiting becomes more established as a natural expression of care it will acquire the same relative stability as is found in spontaneous caring within the community, and such discontinuities will become minimal.

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1. This point is returned to in 5.2.
2. A fortnight study period in March 1973, when two Project staff were supporting about 70 active visitors, recorded 13 personal encounters between Project staff and visitors, 13 outgoing calls from staff to visitors, and 8 incoming calls from visitors to staff -

making an average of 3 - 4 'contacts' each day. See also 5.3.

3. Where an old person had more than one Project visitor, their activities were summarised for analytical purposes: details of the procedure adopted for this are given on Appendix B, p.
4. These and other figures in this section and others relate only to the activities of Project visitors: to obtain a complete picture, account would also need to be taken of the activities of Project staff.
5. This does not include 7 cases where a relative concerned was living with the elderly person.
6. Usually through personal encounter but occasionally by telephone or by mail.
7. The technical limitations of the evaluation are discussed in Section 1.4.
8. Attitudes to volunteers are documented in Aves 1969, Chapter 4.

SUMMARY - CHAPTER 4 VISITORS IN ACTION

Each person who offered to visit through the Project was invited to a briefing session. These sessions brought together small groups of new visitors to learn about the services available to the elderly and to discuss some practical aspects of visiting old people; about half of those invited attended such sessions. Regular meetings were also held with guest speakers and films, to which all visitors were invited, but only a small proportion of visitors showed an interest.

While individuals were actively visiting, Project staff called on them individually in their own homes every two months to talk about their visiting: this was found to be the most natural way of supporting visitors.

Sixty-nine visitors gave information about their activities with 80 elderly people, which showed that they had performed a wide range of tasks on their behalf: the visitors of two-thirds of the old people had undertaken at least five activities listed on a questionnaire, and for one-quarter of old people, visitors had performed ten or more of the tasks listed. The more common activities included shopping, making a cup of tea, taking a present of food, cooking a meal, bringing coals in, taking along books or magazines, and reading letters out loud to someone with poor eyesight. Seven old people had been taken into their visitors homes, and twelve had been visited on Christmas Day. Altogether, over two-fifths of the activities quoted had been done regularly.

The effects of voluntary visiting often extended beyond the visitors' own direct contribution. A number of visitors had contacted various professional services on behalf of the old people they visited; contact with relatives, neighbours and friends of old people had been made by visitors in two-thirds of the cases. Half of these amounted to deliberate contact, relating to a specific issue concerning the old person, rather than chance encounters. On the other side of the coin, over half the old people (42) had been introduced to a visitor's friends or family, and these had often undertaken specific tasks themselves.

Old people were sometimes referred for voluntary visiting at a time when other new provisions were also being made for them, and consequently it was not always possible to determine a visitor's part in any ensuing developments in old people's lives. A follow-up study of 40 old people visited through the Project showed that 22 new services had been provided; one-quarter of old people were engaging in new social activities; and nearly half the old people had new weekly visitors, and it is surmised that Project visitors had sometimes helped to spark this off.

CHAPTER FIVE

WORKING WITH HEALTH AND SOCIAL SERVICE STAFF

"I would like to thank you and your colleagues for the really solid help you are giving residents in the West End. Certainly my patients seem to appreciate it very much and I hope your organisation will be a permanent one."

Letter from a local General Practitioner.

No amount of statutory services for an elderly person can hope to make up fully for the absence of help from relatives, neighbours and friends. Professional Health and Social Services staff are usually quick to appreciate this; and might be expected to find a scheme attractive which sets out to spark off this neighbourly help when it is lacking. By referring an elderly person to such a scheme, the professional can promote a person's welfare in ways which he is unable to pursue himself through pressure of work. He may also find that his own more specialised contribution is enhanced by the neighbourly help arranged in this way.

However, in practice, there are other factors which limit the use professionals make of the Project. There may be a lack of knowledge about the scheme and the scope of its activities - or even about the right way to make a referral. There may be anxieties about the reliability of a new project and the consequences of involving it with an elderly person - or even blatant prejudices against 'volunteers'. Of there may simply be a mild scepticism about new methods of working and a reluctance to try them. Once a professional worker has referred elderly people to a Project, misunderstandings can arise: he may not know what action has been taken about a referral; if help has not subsequently been given, he may not understand the reasons for this and attribute it to ineffectiveness, lack of co-operation or to sheer inefficiency on the part of the Project; even if he knows that a visitor has been arranged through the Project, he may have no indications that anything is being achieved; and when the rare contentious issue arises he may easily misunderstand it. And even if none of these hazards arise, for an individual professional there remains much development before the Project is an integral part of his thinking.

Before discussing the approach to these problems we look at various professionals' use of the Project and their contacts with Project staff.

5.1 WHO HAS USED THE PROJECT

The source of the first 300 referrals to the Health of the Elderly Project is as follows:

TABLE 5A : SOURCE OF THE 300 REFERRALS TO THE PROJECT

SOURCE OF REFERRAL	NUMBER OF OLD PEOPLE
Medical Social Workers	94
Health Visitors	107
Social Workers	26
General Practitioners	18
Other agencies - from voluntary organisations and from other	

professionals	25
From within the community (via shopkeepers, neighbours and including self-referrals)	30
TOTAL	300

Each of these sources of referral displays characteristic patterns of contact with the Project.

Eleven MEDICAL SOCIAL WORKERS have referred elderly people to the Project at various times, but the greatest involvement has been with the Medical Social Worker attached to the Geriatric Unit of the General Hospital: Project staff meet her each week when they attend the 'Social' Ward Round of the Unit. Patients are usually referred when discharge has been arranged either direct from the ward or from convalescence.

Twenty HEALTH VISITORS comprise the largest source of referrals. Early in 1972 each of the twenty-two Health Visitors working in the area was approached and told about the Project. Regular meetings were shortly established with one of the five teams involved, and similar arrangements with the others have developed during the twelve months since that time. It is common for a team to be together when a Project worker is present, and this exposes each individual to more of the Project than she would otherwise meet. Two[1] Geriatric Visitors are included in these teams, and contact with these is greater than with other Health Visitors.

Seventeen SOCIAL WORKERS based at two Area Social Service Teams have been a further source of referrals. Contact was made with the thirty or so Social Workers in these two teams through the Team Leaders early in 1972. Personal encounter between Project Staff and Social Workers has normally related to a specific situation requiring attention; it has not proved possible to meet the full team regularly, although the recent introduction by one team of a monthly coffee-morning for other professional workers is likely to fulfill many of the functions of this. A high turnover of social service staff has sometimes hindered the developments of close working relationships; where pressures of work reduce the numbers in their ongoing caseloads, this has similar effects by lessening the scope for 'feedback'.

Seven GENERAL PRACTITIONERS have referred people directly to the Project (six of these based in one group practice) although several others have contacted the Project concerning people already receiving visitors. In Spring 1972 all 46 General Practitioners working in the area were met individually by Project Staff. General Practitioners often generate an overwhelming impression of business which militates against direct contact: more usually General Practitioners have worked through their Health Visitors, either by leaving it to their discretion to assess those who might benefit through the Health of the Elderly Project or by asking a Health Visitor to refer a particular patient. The amount of contact which takes place between Project Staff and Health Visitors makes this a very satisfactory arrangement. Unfortunately, even when a General Practitioner refers a patient direct to the Project, he often does this through a receptionist who is rarely able to provide all the information desired.

OTHER AGENCIES AND PROFESSIONALS: this category embraces referrals from a local community action group, from Age Concern, from Young Volunteer Force, and from the city's housebound readers' library service. Amongst the other professionals also included in this source of referral are District Nurses, Home Help Organisers and Bath Attendants. In most cases these people have come to hear about the Project through other professionals. No systematic approach has been made to these groups until very recently when HEP Staff discussed the Project with District Nurses at one of their monthly 'in-service' training sessions;

referrals have since been made by them.

REFERRALS FROM WITHIN THE COMMUNITY: in this group are found several shopkeepers and caretakers who have made referrals having met Project staff; several friends, neighbours and relatives of the elderly; and several Project visitors. Also included in this group are those elderly people who have approached the Project directly for help.

Differences emerge between the use made of the Project by the various classes of professionals:

TABLE 5B : THE NUMBER OF REFERRALS MADE BY INDIVIDUALS, RELATED TO THEIR PROFESSIONAL CLASS

Number of referrals made by individuals	Number of G.P.'s	Number of Health Visitors	Number of Social Workers	Number of Medical Social Workers	TOTAL
1	2	4	11	4	21
2 or 3	2	8	4	3	17
4 - 7	3	6	2	2	13
8 - 15	0	0	0	1	1
16 - 31	0	0	0	0	0
32 - 63	0	2*	0	0	2
64 and over	0	0	0	1**	1
TOTAL	7	20	17	11	55

* Geriatric visitors
** MSW attached to Geriatric Unit.

It is noticeable from Table 5B that a large proportion of those Health Visitors who refer people have done so repeatedly; in contrast a large number of Social Workers have used the Project on one occasion only. This may reflect the difference between methods of liaison described above, as well as the turnover of staff in Social Services.

TABLE 5C : USE OF THE PROJECT FOR ONGOING AND ONCE-OFF HELP RELATED TO SOURCE OF REFERRAL

	Ongoing	Once-off	% Ongoing
General Practitioners	17	1	94
Health Visitors	79	28	81
Medical Social Workers	89	6	94
Social Workers	13	13	50
Other Agencies and Professionals	16	8	67
Community	18	12	60
TOTAL	232	68	77

The above figures indicate that amongst professionals, Social Workers are distinctive in using the Project for a greater proportion of 'once-off' jobs. A possible explanation lies in the frequency with which they are confronted with crises demanding specific immediate action, rather than ongoing preventive support. 'Other agencies' and local people are also more regular in seeking help for specific 'once-off' tasks.

5.2 THE OUTCOME OF REFERRALS

'Good' and 'Bad' Referrals

The outcome of 300 referrals made to the Health of the Elderly Project over a period of 15 months from its inception is shown in Table 1A, p. It will be noticed that over half of those people referred for ongoing help were assessed by Project staff as not needing this help or refusing it. The immediate reasons for this have already been discussed but this is obviously a possible source of misunderstanding amongst professionals and needs clarification.

Often a professional worker has foreseen a specific visiting arrangement which would benefit an elderly person. On other occasions he has perhaps felt that some kind of arrangement would be of help but lacked sufficient knowledge about the situation to be more precise. Professional workers have been encouraged to be specific in their proposals, but where this is not possible Project staff would not wish to discourage them from making a referral. This accounts for a proportion of those not subsequently receiving help[2].

When a specific visiting role is foreseen, it is expected that the professional will discuss this with the elderly person before referring her to the Project. It sometimes happens that she is ambivalent towards the suggestion: if he feels that the matter is important, he may still pass it on to the Project, if there seems hope that she will accept help when it is carefully presented to her. On several such occasions a purely 'friendly' visitor has been arranged in the hope that she might be allowed to take on a practical role later. Again, Project staff would not wish to discourage this kind of referral, although it does lead to a number of 'unsuccessful' cases.

Certainly a fierce, and sometimes unrealistic, spirit of independence accounts for some refusals of help; perhaps more often among those who are financially secure. Typical perhaps of this group was a lady of 88, crippled with arthritis, who finally accepted a Home Help only to insist that she did no work. In general, amongst the elderly referred to the Project, those who have refused all statutory services are less likely to accept help from the Project.

Particular problems are raised by those elderly people suffering from mental disorders. It has proved difficult to instigate valuable, long-term visiting arrangements for those who are unable to relate well, and many mentally ill people fall into this category. One lady who springs to mind was a paranoid schizophrenic who spent every day wandering the streets. In cases such as these it is especially important that the professional worker making the referral should have a fairly clear idea of what a visitor might achieve, and should have mooted this with the elderly person concerned.

Importance has been attached to 'locating' the proposed activities of a Project visitor within the context of other help being given to an elderly person. Frequently the assessment visit by a Project worker has revealed unexpected help from other quarters. Where there is a choice in the matter, it has been considered preferable that the friends and neighbours of an old person should respond to increasing needs, rather than place a Project visitor. If the introduction of such a visitor seems likely to damage other relationships a visitor is not placed unless those concerned are under severe strain. Sometimes, particularly in crises, Project staff have contacted the friends of an elderly person who have willingly taken up a practical role suggested to them: in one case an elderly lady had a slight fall and for three days was awaiting hospital admission, during which time she needed all her meals prepared for her. Rather than organise a Project visitor, a HEP worker was able to arrange this between three of her acquaintances, who have retained a greater degree of involvement since that time.

The Outcome of Referrals Related to Source

Just under 40% of those people referred for ongoing help subsequently receive it through the Project, whereas 87% of those referred for help of a 'once-off' nature receive it; this reflects the importance of a careful assessment where ongoing help is being considered.

When the outcome of referrals for ongoing help is viewed, broad differences emerge between referral sources:

TABLE 5D: OUTCOME OF 232 REFERRALS FOR ONGOING HELP, BY SOURCE

	Visitor introduced	No visitor introduced	% for whom visitor was introduced
Social Workers	8	5	62
Health Visitors	38	41	48
General Practitioners	8	9	47
Medical Social Workers	28	61	35
Community	6	12	33
Other agencies and professional workers	3	13	19
TOTAL	91	141	39

'Ongoing' referrals from Social Workers, although small in number, have been generally good; referrals from other agencies and from within the community have been the 'poorest' on average. This suggests that those who have had minimal contact with the Project lack accurate perception of the appropriateness of a potential referral - possibly through their lack of knowledge about the Project. It encourages the hypothesis that contact with professional workers is a relatively effective means of reaching those elderly who need and are ready to accept help, and this is examined in the remainder of this chapter.

The low proportion of those referred by Medical Social Workers who subsequently received help probably arises from difficulties in predicting, from within the hospital setting, the patterns of coping by discharged patients. The Project can act as a safety net for such patients but there are inevitably many who do not in fact need help. Future arrangements might include a service of check calls on discharged patients, undertaken by selected Project visitors, who would then pass to staff only those people likely to need further help[3].

5.3 TOWARDS WORKING RELATIONSHIPS

It will be clear that much is to be gained from effective channels of communication between professional workers and the staff of an organised visiting scheme. In the experience of Project staff this fulfills two functions:

(1) Professional Health and Social Service staff learn about the scheme and how to use it. They come to understand the kind of things which can be arranged, and what the Project visitors are like. They can learn these things through general discussion with Project staff and through case discussion, when staff may use a particular situation to illustrate certain points. This enables professionals to perceive those future situations where the Project can initiate valuable neighbourly support.

(2) Professionals discover what action has been taken about situations which they have referred to the Project, and learn of the subsequent activities of Project visitors. Such 'feedback' to those making referrals is crucial in maintaining good working relationships; it also keeps professionals in touch with developments in an elderly person's situation which they may not otherwise know about, enabling them to take any action necessary, or to know that action is not demanded.

Feedback on Paper

In addition to information provided by word of mouth to professionals making referrals, regular written feedback has also been provided as an ongoing record of Project involvement with specific elderly people. For this purpose a small card was devised suitable for insertion in a patient's or client's file. Such a card is completed for each elderly person being visited through the Project, and a copy of the card is sent every two months to each Professional involved with the elderly person - which may be a General Practitioner, Health Visitor, Social Worker and a Medical Social Worker in some cases. In this way all the professionals involved learn of the Project's activities in a particular situation. The card also names all those professionals involved and indicates which statutory services are being provided, thus encouraging each professional to see his own role in its proper context. The purpose which such cards can serve is well illustrated by one incident when a local General Practitioner telephoned the Project, having noticed a HEP card in the file of a patient who had attended surgery the previous night with stomach pains and loss of appetite. Project staff discovered from the patient's HEP visitor concerned that she had been badly constipated for several weeks and vomited any solid food taken. The old lady had been too embarrassed to tell these things to her doctor, who was able to prescribe effective treatment when given this information.

Day-to-day Contact between Professional Workers and Project Staff

A study period of two weeks duration was designated in March 1973, during which time all contact between field staff and others was recorded, whether by telephone or in person (there was no recorded contact by mail during the fortnight). In the majority of cases this contact related to a specific elderly person:

TABLE 5E : CONTACT BETWEEN PROJECT STAFF AND PROFESSIONAL WORKERS

FORM OF CONTACT	NUMBER OF CONTACTS
Telephone calls:	
(a) Initiated by Project staff	24
(b) Initiated by professionals	19
Total	43
Personal encounters	21
TOTAL	64

The figures show that telephone contact is initiated by Project staff rather than professional workers in the ratio 5:4. Both outgoing and incoming calls were divided equally between 'new' discussion - that is, communication where the two parties concerned had not been in communication with each other previously about this particular person - and 'old' contact - that is, communication where the two parties concerned had been in communication with each other previously about this particular person[4]. Each of the 21 personal encounters usually related to more than one elderly person and could not therefore be placed in one or other of these categories; such encounters occurred half as frequently as telephone contact, and there was no contact by mail during the two weeks concerned.

While effective channels of communication may be maintained in part through telephone contact and through correspondence, there is little doubt that in the Health of the Elderly Project all three have been best achieved through personal encounters, preferably at regular intervals, between Project staff and Health and Social Service staff. This leads to a continuing educational process in which each learns from the other, misunderstandings are ironed out and the Project can develop as a natural complement to statutory provision.

The Response from Professional Workers

Regular meetings between Project staff and Professionals as a method of liaison has developed gradually: consequently there has often been a period of about six months between the first approach to a professional by Project staff and the instigation of regular meetings with him. In order to study the effects of these different levels of contact between Project staff and professionals, three forms of contact have been distinguished, in order of priority:

1. Personal contact at regular meetings. Such meetings are usually held once a fortnight but weekly in a small number of cases.
2. One personal encounter only. This would usually have been when Project staff approached a professional worker to introduce him to the work of the Project.
3. Knowledge of the Project through a colleague working in the same professional team who has experience of referring people to the Project.

At the time of this study, 29 professional workers had experienced regular meetings with Project staff for a period of at least one month: the number of individuals in each profession who had done so is shown in the first row of Table 5F, below the diagonal lines. Above the diagonal lines is shown the number of individuals who had made referrals during these meetings: 21 people had made referrals, which represents a response of 72%.

In the same way, the number of individuals in each profession who had experienced the second or third forms of contact with Project staff for a period of at least one month were recorded (below the diagonal lines); and this was compared to the number of these individuals who had made referrals during this contact (above the diagonal lines). It should be noted that some individuals are represented in more than one row of the table because they had been exposed to different forms of contact successively.

TABLE 5F : THE PROPORTION OF INDIVIDUALS MAKING REFERRALS, RELATED TO THEIR CONTACT WITH PROJECT STAFF

Form of Contact (in order of precedence)	Number of G.P.'s	Number of Health Visitors	Number of Medical Social Workers	Number of Social Workers	TOTAL number of individuals	Percentage of individuals who responded
Within regular meetings -	5 / 7	15 / 21	1 / 1	0 / 0	21 / 29	72
Subsequent to one meeting	6 / 46	7 / 19	5 / 8	6 / 16	24 / 89	27
Referrals made by colleague(s)	0 / 7	1 / 1	4 / 15	11 / 43	16 / 66	24

Clearly, regular personal encounter between professional workers and Project staff encourages a larger number of professionals to make referrals. Failing this, one personal meeting is of help, although this is obscured in the table above by the small response from General Practitioners which takes no account of their use of Health Visitors in making referrals.

Attention has then been given solely to those individuals who have made referrals, in order to study the frequency with which they refer people to the Project. To enable this, the total number of months passed by all professionals within each form of contact has been computed and compared to the total number of referrals made during these 'worker months'.

TABLE 5G : FREQUENCY OF REFERRAL BY INDIVIDUALS USING THE PROJECT, RELATED TO CONTACT WITH PROJECT STAFF

Form of Contact (in order of precedence)	Number of referrals	Number of professional worker-months	Number of elderly referred per worker-month
Within regular meetings	144	176	0.82
Subsequent to one meeting	86	229	0.38
Referrals made by colleagues	26	232	0.11

Again, it is clear that those professional workers who use the Project are encouraged to do so more frequently by encounter with Project staff, especially where this is on a regular basis.

Relationships between Professionals

If the new Health and Social Services are to operate as an integrated care system, it is important that the staff of these services show a mutual recognition of their respective roles and are able to co-operate in their day-to-day work. Any attempts to foster close liaison at the 'grass roots' level is to be commended; the monthly 'open' coffee mornings instituted recently at one Area Social Service Team in Newcastle are a good example of such an attempt.

By working with all the professionals concerned with an elderly person, Project staff are able to encourage each to relate his own contribution to those of others; the feedback cards mentioned earlier also assist in this. At a party held to celebrate the first year of work in the Project, and at which Medical Social Workers, Health Visitors, Social Workers and General Practitioners were represented, it was intriguing to hear professional workers remarking to each other "Well of course I've spoken to you on the 'phone many times, but we've never actually met before". It may be that the voluntary organisation can play a special role in drawing these professions together.

Training and Trainees

On various occasions the Project has been visited by trainee Health Visitors, Medical Social Workers and Social Workers. It would seem that such contact can play a valuable part in educating trainee professionals in informed attitudes towards the role of voluntary schemes in their future work. University and college departments organising such courses might give particular attention to placements with, and inspections of, voluntary schemes, and such schemes might for their part recognise the potential value of these arrangements.

1. Recently increased to three.
2. See Section 2, p.
3. See Chapter 6, p.
4. For the purpose of this study, three Project staff were considered one 'party'.

SUMMARY - CHAPTER 5 WORKING WITH HEALTH AND SOCIAL SERVICE STAFF

Voluntary visiting was seen as complementing the activities of professional Health and Social Services Staff, and the Project pursued methods of working with Health Visitors, Medical Social Workers, General Practitioners and Social Workers, from whom over 80% of referrals subsequently came.

The importance emerged of feedback to professional workers concerning elderly people whom they had referred. Where regular personal meetings between Project staff and professional workers were usual, these were helpful in this way; such meetings were also effective in teaching professionals about the Project and helping them to monitor the needs of their elderly patients or clients. It was found that professionals who met Project staff regularly were more likely to refer people to the Project for help, and those who made referrals did so more frequently than others who had met Project staff only once; these in turn made referrals more frequently than workers who had never met Project staff but whose colleagues had made referrals.

Over one-third of all referrals to the Project were made by twenty Health Visitors, most of whom Project staff met fortnightly at five Health Clinics. Another one-third of referrals were made by eleven Medical Social Workers, and Project staff regularly attended the 'social' ward round at the Geriatric Unit of a General Hospital. Although the old people referred by Medical Social Workers were no less incapacitated than those referred by others, they were less likely, on the whole, to need the help of a voluntary visitor. This was probably because Medical Social Workers tended to see the Project as a 'safety net' service for frail patients to be discharged home, and was not necessarily a cause for concern.

A number of old people were referred by seventeen Social Workers whose requests were more often for 'once-off' jobs, as opposed to voluntary visiting. Referrals were also made by seven General Practitioners, but it was more usual for doctors to liaise with their Health Visitors in order to make referrals.

Professional workers were found to make better referrals, on the whole, than others, again indicating the value of close liaison with them. It is suggested that by supporting the development of such schemes, the Health and Social Services can enhance their own work and assist in the development of the communities which they serve.

CHAPTER SIX

THE RELEVANCE OF THE PROJECT TO ELDERLY PATIENTS IN GENERAL HOSPITALS

The Health of the Elderly Project was set up with a strong link with hospitals in mind and funded by the King Edward Hospital Fund. In assessing the project therefore, the contribution that a community based project, with the features described in the preceding pages, can make to the hospital service must now be examined.

One-third of all referrals to the Project have been made by Medical Social Workers; over two-thirds of those receiving help have had some contact with hospitals:

TABLE 6A : HOSPITAL INVOLVEMENT OF 91 OLD PEOPLE RECEIVING PROJECT VISITORS

Entered hospital since referral to HEP	34
In hospital at time of referral to HEP	12
In hospital within 6 months previous to referral	9
Attends Out-patients	10
Contact of the above form - TOTAL	65
None of the above	26
TOTAL	91

A substantial amount of material has been published by the Hospital Centre and other sources on the organisation of hospital-based voluntary schemes which relate primarily to the care of long-stay patients, and this area of work is being thoroughly explored. In contrast to this, the Health of the Elderly Project is a community-based scheme, operating within a defined geographical boundary, but reaching into hospitals when the occasion arises - and is concerned primarily with short-stay patients.

Before discussing the scope of voluntary visiting in this field one limitation needs to be made quite clear, in order that false expectations will not be raised among hospital staff. 'Voluntary' involvement with an elderly patient will not normally affect any of the most important decisions made by hospital staff, viz whether to admit a patient, what form of treatment is most suitable, when and where the patient is to be sent following his or her stay on the ward. Nor will the hospital staff necessarily find their work improved or made easier in any immediately obvious way by the activities of organised visitors within a community-based project. Certainly their contribution will not be as immediately obvious as that of the Volunteer who brings library books round to patients or plays dominoes with an old man. In fact, he will be just another face at visiting time - at the most there will be a reduction in the number of patients with few or no visitors. If the support of hospital staff is sought therefore, special steps must be taken to keep them informed about the activities of the voluntary visitors.

Through the organisation of a Project, local people can contribute to the well-being of elderly patients in two complementary areas:

A. they can assist the hospital service in achieving its objectives by enhancing both the short-

term and long-term effects of treatment.

B. They can improve the personal experience of a short stay in hospital for an elderly person.

6.1 ENHANCING THE SHORT-TERM AND LONG-TERM EFFECTS OF TREATMENT

(1) Perpetuating the benefits of hospital treatment

The combined effects of medical treatment, nursing care, a healthy diet and physiotherapy can produce impressive effects on an elderly hospital patient. Unfortunately such a patient's discharge into adverse home conditions will sometimes quickly undo these benefits. The provision of adequate practical support at home through statutory services, day care and luncheon clubs, and through organised voluntary visiting, where appropriate, plays an important part in tackling this problem: but this is only a partial solution where the elderly person falls into certain rigid patterns of behaviour associated with home and which are unhealthy in their effects. "She doesn't seem to want to help herself" expresses this kind of situation where the root of the problem lies with what might be loosely termed the elderly person's 'self-image' and its associated 'life-style'.

It is generally recognised that a continuing relationship between two people can sometimes provide the one with quite powerful means of influencing the behaviour of the other - casework provides a practical example of this. In this way Social Workers and Health Visitors with their educational brief can work to change unhealthy attitudes in an elderly person. However, inflexibility can make changes in the behaviour patterns of an old person a slow progress, and these desired changes may not demand sophisticated casework skills. These changes are perhaps best achieved through the gentle insistence of friends, neighbours, relatives and organised voluntary visitors of the elderly over a long period of time. Incidentally Social Workers, Medical Social Workers and Health Visitors might therefore give extra attention to their own part in explaining to a patient's friends and relatives the significance of the patient's behaviour patterns, and in subsequently supporting these people in their efforts to influence the patient's behaviour.

An example of such activity is that of an emaciated elderly lady who reputedly lived on tea and sanatogen. She had refused meals on wheels having tried them and disliked them, and was discharged from hospital one week after her admission having been exhorted to eat more. A local HEP housewife called three times each week following her discharge and prepared light meals to her fancy which she sat and ate with her. The lady still has recurrent stomach troubles but has become more spritely and cheerful. In other cases also the 'social' aspect of eating with a guest has encouraged elderly patients to improve their eating habits.

Another example is that of an obese lady who was 'remobilised' in hospital and sent home; two years previously the same had happened but she had rapidly become chairfast following her discharge. On this second occasion a voluntary visitor living in the same street and a District Nurse have worked to keep her mobile by walking her round the room each time one of them calls.

(2) A 'landing service' for discharged patients

As far as hospital staff can predict, it may seem that an elderly patient will cope well once resettled in her own home, with the patterns of community and statutory support established again, but there will often be some concern for her on the day or two immediately following discharge. Which friends or relatives know of her discharge? Will they call in? Will the neighbours spot the ambulance or will they not know she is home again? What condition is

the house in - is there food there, and what about the fire?

A check call on the day of discharge or the following morning does not require the skills of a Social Worker or Health Visitor and is effectively performed by a local person on a 'once-off' basis. The visit may entail lighting a fire in the house and buying bread, milk, etc.; preparing a light snack; alerting neighbours that the elderly person is home and passing on to them any messages concerning shopping or other help usually given; checking that she understands which pills she has to take and when, and that pension arrangements are in hand. Such tasks have been undertaken with a number of discharged patients in the Health of the Elderly Project.

The organisation of this service makes different demands from that of regular visiting; it is not so important that a visitor lives nearby; and it can be provided either by a community-based project, or as an extension of a hospital-based project. In the latter case, a volunteer active on the wards within a well-established scheme could undertake such check visits with the advantage of a familiar face. A prime consideration is the need for excellent communication with the hospital, so that precise discharge dates are known as early as possible, giving time for the visit to be organised.

(3) Getting patients to enter hospital

The extent to which organised visitors can prevent hospitalisation amongst the elderly is very difficult to ascertain; if this is one of the effects of increased neighbourly support through an organised visiting scheme, it seems likely to operate over a long period of time. In practice a visitor is often confronted with an elderly person who would probably benefit from treatment as a hospital in-patient, and he can sometimes be instrumental in persuading the patient to accept hospital admission. This can mean allaying specific fears and clarifying misunderstandings about intended treatment and its purpose; and can involve advising a doctor of these fears in order that he may take them into account in his medical assessment.

One lady, 'Miss G.', who lived with her elderly brother, had always been extremely active, doing most household chores herself, until she became convinced that she was suffering from a terminal condition - despite the fact that all tests had proved negative. Miss G.'s health declined rapidly, she became bedfast and suffered a series of asthmatic attacks. Her brother also suffered during this time as on occasion his sister kept him up all night. It became clear that if Miss G. did not receive hospital treatment soon she would become an urgent psychiatric problem. With support from two HEP visitors Miss G. came to accept the idea of entering hospital, with re-assurance that they would give her brother any necessary help while she was there. Through liaison with the Health Visitor and a Medical Social Worker, who acted promptly, she was soon admitted; a visitor bought a necessary bed-jacket and slippers in town for her and helped change her and pack ready for the arrival of the ambulance, and her brother was visited regularly while she was in hospital.

In another case a GP had despaired of ever getting an elderly lady to attend an outpatients appointment: she had repeatedly changed her mind when the ambulance man appeared at the door. After several months of visiting through HEP it emerged that one reason for her behaviour was her dirty condition which would have been exposed, to her shame, at a medical examination. A Bath Attendant was arranged and with much further encouragement she attended outpatients, escorted by her HEP friend.

(4) Providing information to Hospital Staff concerning social factors in the home situation

In order to assess how well an elderly patient will fare in the community it is necessary to

build up a fairly detailed picture of the 'social' situation at home. Occasionally, where an elderly person has been socially isolated an organised visitor has been in a position to provide valuable details about the home situation, if he or she has been visiting regularly prior to admission: one example of this concerns an elderly lady who attended out-patients department and her visitor felt that the examining doctor should be made aware that the patient regularly consumed half a bottle of sherry and a bottle of Guinness daily.

In another case an examining doctor was advised that a particularly elderly lady had coped well at home until her three closest friends had died in quick succession, since when she had deteriorated markedly, and she was considering entering a residential home.

However, a reasonable social assessment should normally be secured by gathering information from the patient herself and from her visitors on the ward, supported by a domiciliary visit by a Medical Social Worker who has contacted neighbours where appropriate, and liaised where necessary with a Health Visitor.

(5) Providing information in other ways:

(a) to hospital staff concerning the progress of patients who have been discharged home
It must be stressed that such information is rarely of the kind which demands a response or action on the part of hospital staff: this purpose is normally served by follow-up out-patients appointments. Rather, such information is of human interest and may stimulate hospital staff to develop a widened outlook towards their patients.

(b) to G.P.'s, Health Visitors and Social Workers concerning the progress of their patients while in hospital
The close links which a visiting organiser can maintain with both Hospital and Community staff raises the possibility of his acting as a channel of communication between them. This is only appropriate at a very elementary level, and is not suited to the transference of medical data. Information concerning plans for patients is also unsuitable material as these plans may be altered. Important information, especially that requiring decisions, must obviously be sent by the usual channels and not through a visiting organiser.

6.2 LOCAL PEOPLE CAN IMPROVE THE PERSONAL EXPERIENCE OF A SHORT STAY IN HOSPITAL FOR AN ELDERLY PERSON

To leave your own home and enter hospital is to encounter an almost total change in one's immediate experience. The discontinuity with the usual pattern of day-to-day life can be very disorienting, and there is a danger that an old person experiencing this may lose the will to recover. The adverse effects of this for an elderly patient's prognosis are surely widely experienced, even if they have so far defied documentation.

One means of maximising the continuity with a patient's normal day-to-day life is by the appropriate organisation of the in-patient's day to correspond as far as possible with their normal pattern of life. This matter is presently under review by the Central Health Services Council Committee on the Organisation of the In-patient's Day.

The other method of fostering continuity is by taking steps to maintain the complex of relationships which usually surrounds a person living at home by maintaining his or her contact with the community while in hospital. Some ways in which this can be done are as follows:

1. Arranging the visiting of isolated elderly patients by organised voluntary visitors, preferably commencing prior to the patient's admission

That which is commonly termed 'idle conversation' is a common part of daily life which increases in importance for those who are housebound and otherwise cut off from the life of the community. In hospital this natural social intercourse can be absent unless a particularly lively group of patients are put together, except when visitors come. Consequently those patients who have a few or no visitors sometimes greatly appreciate the friendship of a voluntary visitor. Clearly if an organised visitor can strike up a friendship with a patient before her admission, even if relatively few calls have been made, the value of the hospital visiting will be enhanced and is more likely to give her a sense of continuity with her usual life at home. Prior to admission she can also gain re-assurance from the fact that her friend will continue to visit her once in hospital; when discharge is pending, again there is re-assurance that someone living nearby will be able to give any help necessary.

It would be impractical and inefficient to contact every elderly person awaiting hospital admission in order to assess the need for and acceptability of an organised visitor: contact with Health Visitors, GP's and Social Workers who have knowledge of the elderly person's home situation is necessary in order to reach the people most likely to benefit from organised visiting. Clearly a community-based project can be effective here in liaising with professional workers and in enabling local people to visit the elderly living close to their own homes. In the Health of the Elderly Project, of 25 patients visited by HEP local people while in hospital, 21 had already established their friendship before admission.

The value of using a community-based project to initiate visiting with patients who have already entered hospital is more questionable. The destination of an elderly hospital patient is often difficult to predict with any certainty; and it is only if she returns home that the proximity of an organised visitor is relevant. By the time it is known that the patient will be discharged home, there is little more than the opportunity to introduce an organised visitor to the patient before discharge. Therefore if there is a clear value in visiting a particular patient in hospital, whose destination is uncertain, it is suggested that this is best arranged through a hospital-based project, and that voluntary visitors be encouraged to visit the patient on one or two occasions soon after their discharge from hospital, whether home or into Residential Care, or into Long-stay Hospital.

2. Providing transport for friends and relatives of patients otherwise unable to visit

The above arguments for arranging organised visitors to minimise discontinuity clearly apply much more strongly to visitors already well known to the patient. Any step to secure a firmer continuation of community contacts while in hospital should be encouraged. One obvious way of doing this is to extend visiting hours and make them more flexible as far as possible. Another way, particularly relevant to elderly patients whose friends and relatives are often also elderly and unable to ride buses, is to provide transport for such visitors.

There are two extreme responses to be found amongst friends and relatives of an elderly person who is admitted to hospital. One is to identify this as a crisis, as a time when one's friendly support is especially important and a temporarily increased commitment is demanded. The other is to recognise that the usual practical supportive role is redundant, that the elderly person is being well cared for elsewhere, and to assume that one is largely released from any responsibility or concern until such time as the elderly person comes home again. The impression is that relatives who live some way away and normally provide little support tend towards the former extreme, while neighbours tend towards the latter extreme. Any attempt to shift the response towards the former extreme is clearly to be encouraged, e.g.

by arranging transport for elderly visitors. One approach might be to send information about the transport service to elderly patients prior to admission, who would list the names and addresses of any elderly friends wishing to visit but requiring transport. The list could be collected by the transport organiser from the patient shortly after admission. Certainly a transport service will be relatively limited in its potential if it waits for patients to mention visitors' transport difficulties. Existing voluntary transport services might expand and develop in this way - perhaps as part of a wider service providing voluntary transport to patients in long-stay hospitals and Residential Homes, and to housebound friends and relatives. At present these types of service are being provided in a limited way by the Health of the Elderly Project.

Other possibilities are to encourage Home Helps to visit their elderly people when they enter hospital; and to ensure that every patient awaiting admission has written notification of visiting hours which can be passed on to friends.

3. A channel of communication with friends and neighbours concerning domestic arrangements, etc.

   Elderly patients wish to contact friends and relatives not visiting them for all sorts of reasons. Volunteers can write letters or telephone on a patient's behalf, and where necessary a volunteer, preferably with a car, can visit friends and relatives in order, for example, to tie up discharge arrangements.

4. Mediation between patient and hospital staff

   While hospital staff should always take every possible step to explain treatment, and its purposes, to a patient in terms that can easily be understood, basic misunderstandings still arise; and where an organised visitor has had the necessary facts explained at an elementary level, she can sometimes, with patience, succeed in ironing things out.

It will be clear that the majority of activities described in this chapter are appropriate to a community-based scheme; however some could be developed as effectively within hospital-based projects. In particular it is suggested that voluntary schemes of the kind co-ordinated by Hospital Voluntary Organisers and Hospital League of Friends might liaise with hospital staff in setting up a 'landing service' for discharged patients, and in providing a transport service for incapacitated friends and relatives of patients who would otherwise be unable to visit.

SUMMARY - CHAPTER 6

THE RELEVANCE OF THE PROJECT TO ELDERLY PATIENTS IN GENERAL HOSPITALS

Voluntary activity with hospital patients can be organised in various ways: one way is through a hospital-based scheme, and this is particularly suited to voluntary work with long-stay patients; another way is through a community-based scheme, which operates within a defined geographical boundary and reaches into the hospital when the situation demands - such a scheme is concerned primarily with short-stay patients. The Health of the Elderly Project has been a community-based scheme, and experience in organising it has led to proposals concerning the scope of such schemes.

It is proposed that voluntary visitors can assist the hospital service in achieving its objectives by enhancing the effects of treatment. They can do this by providing after-care which encourages a healthy 'life-style' - sometimes helping to maintain good eating habits or improved mobility which has been attained within the hospital; visitors can provide a service of check calls on patients on the day of their discharge; and occasionally they can allay the fears of isolated individuals who need hospital treatment but who refuse it, and influence them to accept treatment.

Voluntary visitors can also improve the personal experience of a short stay in hospital for an old person. By visiting isolated elderly patients in hospital, after discharge and before their admission if possible, visitors can lessen the likelihood of disorientation; four-fifths of those attended by Project visitors in hospital had already established their friendship before admission. Visitors can also provide a valuable channel of communication between elderly patients and their friends and neighbours concerning domestic arrangements; they can provide transport for friends and relatives of patients who could otherwise be unable to visit in hospital - thus promoting a sense of continuity with the patients' day-to-day life at home.

RECOMMENDATIONS

1. Voluntary visiting schemes can seek to provide care for the aged of a quality comparable to that often given by relatives, neighbours and friends. This may be pursued through the intense recruitment of voluntary visitors in a small area and their introduction to only one or two elderly people each. Voluntary organisations concerned with the old, especially those with national experience, should consider initiating new schemes and developing certain existing schemes for this purpose; Local Authority Social Service Departments and Area Health Authorities should consider financing such schemes which can provide a valuable backcloth to their own services (Section 3.1).

2. All organisations undertaking voluntary visiting, but particularly those of the form outlined in Recommendation 1, should consider arranging regular personal meetings with Professional Health and Social Service staff in order to liaise effectively with them. This includes Health Visitors, Social Workers, General Practitioners and Medical Social Workers, whose mutual contact with visiting organisers can also encourage them to liaise more closely with each other (Section 5.3).

3. The role of the professional worker in preventive domiciliary visiting of the elderly should be developed. Through regular check calls such a worker is able to identify medical and social problems early, and refer them to a General Practitioner, Social Worker or another, where appropriate; she can also determine systematically the need for statutory and voluntary services, and take steps to secure them, a task too complex for many elderly people. Such a worker can be complementary in her activities to the General Practitioner and the Social Worker, and her training should reflect the preventive role outlined above.

   Particular consideration should be given to the development of Health Visiting or specialist Geriatric Visiting along these lines (Section 3.5).

4. The training of Professional Health and Social Service staff should include instruction on the role of voluntary visiting schemes in their future work. Meetings with the staff of visiting schemes should be arranged, and where possible students should be given placements at these schemes (Section 5.3).

5. The range of services available to the elderly should not need to expand indefinitely; certain tasks are more appropriate to relatives, neighbours and friends, and voluntary visitors. However, a demand remains at present for certain new services, and particular consideration should be given to the following:

   (i) an effective gardening service adequately financed and able to undertake regular gardening duties for disabled people (Section 3.5).

   (ii) an adequate 'Dirty Squad' within the Home Help Service to clean out exceptionally squalid houses, with preferential rates of pay if necessary (Section 3.5).

   (iii) a domiciliary hairdressing service, for housebound men and women, arranged possibly through the subsidy of commercial hairdressers on a 'per capita' basis (Section 3.5).

   (iv) a statutory transport service to take immobile elderly people to opticians (Section 2.2).

6. All those concerned with the organisation and maintenance of any group activity should recognise a responsibility towards those physically incapacitated people who would like to participate in the group. Any members of groups who have a car should be encouraged to transport an immobile person to the group. Such arrangements should be pursued, for example, in Over-60's clubs, luncheon clubs, pubs and social clubs, churches and Adult Education Centres.

7. New attention should be given to those mentally ill people living alone at home, including numbers in middle or old age, who have not received treatment for some time. Further studies should be made of their particular problems and action should be recommended.

   Such people are particularly at risk during rehousing. When issuing a compulsory purchase order Housing Departments should liaise at the earliest opportunity with Health and Social Service Departments in order to identify such individuals and anticipate their problems (Section 2.2).

8. The plight of many isolated old men who live alone demands attention: A Project should be established to explore ways of restoring dignity to the lives of elderly men. This would probably include working with local groups to encourage them in bringing old men into their corporate life. Pre-retirement counselling should be adopted more widely and more part-time jobs and sheltered workshops should be made available to old men, as preventive measures (Section 2.4).

9. The organisers of voluntary work within hospitals should consider developing:

   (a) A service of check calls on isolated elderly patients at home on their day of discharge (Section 6.1).

   (b) A transport service for those friends, neighbours and relatives of elderly patients who would otherwise be unable to visit (Section 6.2).

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Appendix A. FOUR DETAILED CASE STUDIES

Here and there elderly people are to be found who live quite appalling lives by the standards of society, and who are well known to Social and Health Services and perhaps to local people as well. All attempts to improve their quality of life seem to fail and there is little hope that much would be achieved by arranging for a local person to visit. Such was the problem with Mary:

Some years ago Mary had taken to her bed with arthritis and had become bedridden and wasted since. She lived in squalid conditions with her adult son and a sheepdog in a semi-detached house on a council estate. Her son returned to the home only at night to sleep on the settee and gave his mother little help. Mary was well known to priests and church workers, voluntary agencies and neighbours alike, and received a Home Help, Meals on Wheels, a District Nurse and a Bath Attendant. There was some hesitation about placing a Project visitor in a situation where so many were already involved, but it was felt 'there must be something which can be done' and Mary was introduced to Sheila, who lived nearby.

Sheila had a full-time job, so she would visit Mary twice each week in the evenings. As she got to know the old lady, she used to do a little washing, and bring her food; and when it was soon clear that Mary was in more need of food at other times of the day and at weekends, Sheila brought her a wide-necked flask in which stews, vegetables and soups would stay hot until they were wanted. She would also bring magazines which Mary was fond of reading, and found her a transistor radio. A basic problem was the condition in which Mary lived. The house was very dirty and insects were able to live between the house, the dog and the old lady; Sheila contacted the RSPCA, the PDSA and the Cat and Dog Shelter who were all unable to help; and buying flea powder and rubbing it into the dog proved of no use either, so she enlisted the help of a lad from a local Young Volunteer Force team and bathed the dog in a special wash obtained from the Cat and Dog Shelter. This led to a slight improvement - Sheila took no more fleas home to her husband! But the house remained dirty, and the next step was to have this cleaned out. Sheila negotiated with Mary's priest to get her into a voluntary home for a period while the Young Volunteer Force cleaned the house, during which time the dog could be treated at kennels and the house fumigated. However, the home would not accept Mary as she was bedfast, but arrangements were made instead through Social Services Department for her to be taken into a Local Authority Home for one day. When the day came, Mary changed her mind and refused to go. Nevertheless, the Young Volunteer Force did clean out the house, and it was fumigated, and the dog was effectively treated during a week at the Cat and Dog Shelter.

From time to time Sheila has liaised with Mary's Health Visitor: through her, a fireguard was obtained - there was the danger that if anything had fallen from the open fire Mary would not have been able to prevent a fire; a commode was provided and through the Health Visitor and General Practitioner, Sheila applied for a constant attendance allowance of some form: the Department of Health and Social Security, who had previously treated Mary as living alone, promptly reduced her benefit, and the constant attendance allowance was refused. Only after further negotiations by the Health Visitor was the benefit restored to its previous level.

Mary's immediate neighbour would come in most days of the week to light her fire in the morning and prepare breakfast, but she grew unreliable when she was offered a new house and prepared to move within a couple of months. Sheila lived nearly half a mile away - a little too far to come every morning to light Mary's fire herself - so she tried paying some local children who often called in on Mary to do this, but they did not prove reliable. Instead Sheila was able to obtain

from Age Concern a grant for an electric overblanket for her bed, and since she bought this the problem of the unlit fire has been of less importance. But in spite of all that has been done, Sheila feels that most of all Mary has appreciated her company and a good chat.

The pitiful plight of many elderly men living alone has been referred to elsewhere: and it has proved harder to establish stable visiting arrangements with these than with elderly women, for various reasons. However, a few distinctly valuable relationships have been sparked off and Anne's involvement with John is one of them:

John was referred by a Medical Social Worker who was concerned about how he would manage when discharged home. He was met by one of the Project team while in convalescence: the one practical role for a visitor to appear from this was transporting John to the local pub, which he could not otherwise get to. When John came home to his upstairs flat, this was arranged through Pete, a young local man, who drove him each week to the pub and brought him home.

John was getting a Home Help twice a week but would not have Meals on Wheels, and both his Health Visitor and Social Worker were growing concerned about his nutrition. It was decided to introduce Anne, a young lady living nearby, to prepare meals for him and to do some shopping which his Home Help had no time to do. Anne soon struck up a friendship with John and had a key cut so that she could come in without him having to descend the stairs, which he found difficult. One of the first things she did was to tack down some dangerously loose carpeting on those stairs. Anne started calling twice each week, usually taking home-made soup or broth, and often did shopping - which came to include bottle of his much-loved Newcastle Amber. After two months his Health Visitor succeeded in her negotiations to get his Home Help increased to five days a week. Anne had come to know his Home Help and would time her visits so that she arrived just before the Home Help left, in order to chat with her and each work out how best to use her time. Anne would often take John's washing to the launderette and collect prescriptions for him. She also kept in touch with a young couple who had recently moved in downstairs from John and who held a key for his flat: for example when Anne was going on holiday she let them know so that they could keep a special eye on him. After a while they began preparing a Sunday lunch for him, an arrangement which has continued. Anne also arranged for the dustman to remove some items of furniture which had cluttered his back yard for some time.

For months John would draw attention to his broken radio and say how he was going to get it mended one day. Anne made enquiries at the Project about radios and she was able to get a new one for him through the 'Radios for the Disabled' scheme, having first met his doctor in order to obtain the medical information necessary to the application. John was delighted when she presented it to him.

All this time Anne took John regularly to his pub, where he was teased about his 'girlfriend'. One day he decided he would like to go somewhere else - to visit his nephew whom he had not seen since a family tiff four years ago. This was done: the nephew was very startled to find his Uncle John at the door, but after the initial strain a very amiable time was had.

Not every elderly person finds it easy to accept the help which he or she so very much needs and which is so naturally offered by others. It is sometimes seen as 'charity' and as a threat to the recipient's integrity, perhaps especially amongst the higher social classes. But these attitudes can change, as was shown by Miss J.:

Miss J. was a fiercely independent old lady of 89 who lived a very isolated existence in a tall block of flast. She received Meals on Wheels seven days a week, but did not have a Home Help as she refused to disclose the amount of money she had in the bank, and this information was needed in order to calculate the charge to her for that service. She was admitted to hospital where she was approached by Project staff but was strongly opposed to the idea of having a visitor call regularly to help her when she was discharged - in spite of her difficulty in managing at home.

Her long journey home from convalescence in an ambulance apparently left her in a state of confusion and she was re-admitted to hospital the following day. On the second occasion she very cautiously accepted the suggestion that a Project visitor call regularly. When Miss J. came home this second time, her niece took some time off from work in order to help her aunt, who was still mildly confused, and for some days slept on her aunt's floor in order to watch the old lady at night and to prepare her a good breakfast in the morning. This was made especially important because Miss J. was quite incapable of cooking and would be without food until the evening when the niece returned. Previous to hospital admission, she had received Meals on Wheels 7 days a week, but while in hospital her Meals on Wheels had been re-allocated to other people and on her discharge she was only provided with them once a week. The niece was under some strain and so Project staff undertook to arrange for local people to prepare lunch for Miss J. on four days of the week, while applying pressure for Meals on Wheels to be increased at the earliest opportunity. A Project worker kept in close contact with the niece who no longer slept at her aunts but instead prepared breakfast on the previous evening. It usually proves difficult to find someone who will start visiting on four days of the week, and in this case three visitors who knew each other well shared between them the responsibility of providing the meals. Over the following months Miss J. mellowed and grew noticeably more friendly and open towards her visitors, who also helped a little around the house.

As Meals on Wheels came more often, two visitors withdrew and after 12 weeks the service had been restored to seven days a week. The third visitor called less often having introduced her daughter, Ruth, a young mum who now visited Miss J. regularly with her young son, which brought the old lady much pleasure. Ruth was still visiting 6 months later when Miss J. died suddenly.

But a spirit of independence, expressing itself in courage and determination in the face of those restrictions imposed by ageing, is surely a good and natural thing, to be respected and encouraged by everyone who knows elderly people. This is illustrated by Christine's part in Mrs. P's recent life.....

Mrs. P. was an independent lady in her sixties who lived alone in modern supervised accommodation. She has suffered from much illness and had been more or less bedfast for two months when she was referred to the Project. Her Health Visitor thought that someone might valuably prepare a light snack in the early evening.

Christine began visiting several times weekly, preparing light snacks for her, making sure that Mrs. P. kept to her low-fat diet. Sometimes when Mrs. P. felt well enough Christine would allow her to prepare food for both of them, which gave the old lady great satisfaction. On each evening Christine would take away a list of shopping to bring on her next visit.

For many months Mrs. P. had regretted losing touch with her relatives, including one in Belfast, to whom she had been accustomed to writing regularly, and who were concerned about Mrs. P. in

her illness; so Christine regularly wrote letters to them which were dictated by Mrs. P., and sometimes helped her to read the replies, all of which greatly pleased the old lady.

Her cooking was rather restricted by the small number of pots and pans which she owned, and she also lacked sufficient sheets, so Christine applied to the Department of Health and Social Security for a grant and bought these for her. She also contacted the Meals on Wheels service who agreed to increase Mrs. P.'s number of meals to five each week - for several years she had been accustomed to having them twice weekly.

After about six weeks Mrs. P. was admitted to a Hospital Geriatric Unit where Christine continued to visit her. It emerged here that part of her problem was the confusing range of tablets which she had built up and did not take properly. This was reduced to 3 bottles of tablets which Mrs. P.'s nurse listed on a card with clear instructions before her discharge home.

Another problem which troubled Mrs. P. was her ill-fitting dentures. After ringing around a number of dentists, Christine found one who was willing to make domiciliary visits. He made several calls on Mrs. P., during which time he prepared and fitted new, more comfortable dentures for her.

For some time Mrs. P. has wanted very much to be rehoused: she often finds her room, which faces south, unbearably hot. Her improvement after a stay in hospital and convalescence was marked, but she gradually deteriorated: she later had a holiday, organised by her Social Worker, in a Local Authority Rest Home - again Christine was active, packing in preparation and obtaining a grant from the DHSS for the holiday - and again she improved greatly, only to grow worse again later. Her rehousing is still awaited but she is one of many.

Appendix B. THE EXECUTION OF RESEARCH

B.1 THE EXECUTION OF QUESTIONNAIRES

The Questionnaires to Old People

Project staff administered questionnaires to 50 old people who were introduced to Project visitors. These were usually administered about one month after visiting commenced, in cases where a visitor had been introduced shortly after an assessment visit: on other occasions a visitor had not yet been placed.

TABLE B.1 : TIMING OF COMPLETION OF 50 QUESTIONNAIRES TO OLD PEOPLE RECEIVING PROJECT VISITORS

May/June 1972	18
July/August	11
Sept./Oct.	7
Nov./Dec.	10
Jan./Feb. 1973	4
TOTAL	50

In April 1973, follow-up interviews were concluded with 40 of these old people who were still at home at that time[1]. The length of follow-up periods therefore varied from 3 to 11 months (Table B.2).

TABLE B.2 : LENGTH OF FOLLOW-UP PERIOD FOR 50 OLD PEOPLE

Number of months	3 or 4	5 or 6	7 or 8	9 or 10	11
Number of old people	4	10	7	11	18

Early in 1973 the opportunity arose to complete questionnaires with those elderly people for whom Project visitors had not been arranged. This involved approaching all such people who had been referred to the Project in the 15 months since its inception in November, 1971. To assist comparative studies between these people and those with whom visitors had been placed, it was necessary at this stage to approach 19 of those 41 people in the latter group with whom questionnaires had not been completed. This was because the reasons for not previously completing these 19 questionnaires could not be applied to the new group now being interviewed, for whom visitors had not been arranged[2].

It proved possible to complete 13 of these questionnaires, enabling comparative studies between 63 old people receiving Project visitors, and 67 old people not introduced to Project visitors with whom students were able to complete questionnaires (Tables B.3, B.4).

TABLE B.3 : NUMBERS OF QUESTIONNAIRES COMPLETED WITH OLD PEOPLE

	RECEIVING VISITORS		NOT RECEIVING VISITORS
	Questionnaire	Follow-up interview	Questionnaire
Questionnaires completed by Field Staff May '72 till Jan. '73	50		
Questionnaires and follow-up interviews completed in March/April 1973	13	40	
Questionnaires completed by students in March 1973			67
TOTALS	63	40	67

TABLE B.4 : COMPLETION OF QUESTIONNAIRES AND FOLLOW-UP INTERVIEW WITH OLD PEOPLE RECEIVING PROJECT VISITORS

LOCATION OF OLD PERSON AND COMPLETION OF QUESTIONNAIRES FOLLOWING INTRODUCTION OF VISITORS MAY 1972 - JANUARY 1973	LOCATION OF OLD PERSON AND COMPLETION OF QUESTIONNAIRES IN MARCH/APRIL 1973				
	Questionnaire completed at home	Questionnaire not completed - refused, deaf, aphasic confused etc. at home	In hospital	Left community	TOTAL
At Home					
Questionnaire completed	(40)*	0	1	9	50
Not completed - refused, deaf, aphasic, confused	0	8	0	2	10
Not completed - reason included for comparative studies	12	4	0	1	17
In Hospital	1	0	0	1	2
Left the Community - died, entered institution or moved in with relatives	0	0	0	12	12
TOTALS	13 + (40)*	12	1	25	91

* These were follow-up interviews (c.f. Appendix C) not questionnaires.

Comparative studies between those introduced to Project visitors and those for whom this was not arranged may be limited in their value by the differences in timing of questionnaires to these two groups. Questionnaires to the latter group were administered at a time when 20 of them had left their own homes, and information could not therefore be gained about their home life: whereas of 25 old people in the former group who had similarly left their homes, questionnaires had already been successfully completed with 9 of these (Table B.5). It is possible that these 9 people were worse off in various ways than those remaining in the community: this would tend to bias results for those not receiving Project visitors favourably in these ways, compared to people receiving Project visitors, although figures were small. On the other hand, at the time they were interviewed the former group had been at home longer since assessment than the latter group, and they may have undergone relatively greater deterioration in that time: this would tend to bias results in the opposite direction.

TABLE B.5 : COMPLETION OF QUESTIONNAIRES RELATED TO LOCATION ON FOLLOW-UP

	NOT RECEIVING PROJECT VISITORS		RECEIVING PROJECT VISITORS	
	Total number of elderly	Number of questionnaires completed	Total number of elderly	Number of questionnaires completed
Questionnaire completed	67	67	53	53
Not completed: refused, etc.	7	0	4	0
Unable to complete - deaf, confused, etc.	8	0	8	0
In hospital during follow-up period	1	0	1	1
Moved in with relatives	2	0	1	0
Entered residential care	3	0	14	5
Entered long-stay hospital	2	0	1	0
Died	13	0	9	4
TOTALS:	103	67	91	63

The Questionnaires with Project Visitors

Postal questionnaires were completed in May 1973 by 90 Project visitors; 69 of these questionnaires included sections concerning the visitor's activities with one or more old people. The majority of these were followed by interviews from Project staff who explored certain questions in greater depth.

TABLE B.6 : NUMBER OF PROJECT VISITORS COMPLETING QUESTIONNAIRES

	Part One: 'Background' Section	Part Two: Relating to Visiting Activities within Project
Postal questionnaires	90	69
Follow-up Interviews	87	68

Some people had visited more than one elderly person through the Project and they were sometimes asked, therefore, to complete more than one questionnaire; however, questionnaires were only completed when there had been substantial on-going involvement with the elderly person concerned:

TABLE B.7 : NUMBER OF ELDERLY PEOPLE VISITED BY, AND NUMBER OF QUESTIONNAIRES COMPLETED BY, EACH PROJECT VISITOR

	Number ('X') of elderly					TOTAL NUMBER OF VISITORS
	0	1	2	3	4	
Number of visitors who have visited 'X' old people	23*	59	23	3	3	111
Number of visitors completing questionnaires for 'X' old people	42	48	16	3	2	111

Total number of questionnaires completed = (48) + 2 x (16) + 3 x (3) + 4 x (2) = 97

* 5 of these people, though not undertaking regular visiting, had assisted with 'once-off' tasks in the Project.

On the other hand, some elderly people had been attended by more than one Project visitor, either visiting concurrently or in succession. In this manner, the 97 'activity' questionnaires completed by visitors related to 80 old people:

TABLE B.8 : NUMBER OF H.E.P. PEOPLE VISITING, AND NUMBER OF QUESTIONNAIRES COMPLETED BY VISITORS ON BEHALF OF, EACH ELDERLY PERSON

	Number ('Y') of HEP visitors				TOTAL NUMBER OF OLD PEOPLE
	1	2	3	4	
Number of elderly attended by 'Y' HEP visitors	62	24	4	1	91
Number of elderly on whose behalf 'Y' questionnaires were completed by visitors	66	11	3	0	80

Total number completed = (66) + 2 x (11) + 3 x (3) = 97

B.2 THE RECORDING OF DATA

Summing the 'Activity' Questionnaire with Visitors

It was desired to relate the activities of visitors with elderly people in the Project to some characteristics of visitors. Where visitors had completed a questionnaire for their activities with one old person, this was straightforward. However, where they had completed questionnaires relating to activities with more than one old person, it was necessary to devise means of summarising these activities for each visitor - these were called VISITOR-CENTRED SUMMARIES [3].

It was also wished to relate the activities of visitors to the characteristics of the old people whom they were visiting. Again, where an old person had one Project visitor, this raised no problem, but where they had more than one visitor, whether visiting concurrently or in succession, a means was necessary of summarising the activities of all visitors on behalf of the elderly person, to provide ELDERLY PERSON-CENTRED SUMMARIES.

In both cases, the method adopted was to order the possible answers to any given question by precedence. When summarising the answers to this question, as given on two or more questionnaires, the answer of highest precedence amongst those given was then recorded.

The precedence order designated to the possible answers of each question were as follows[4], and were the same for both visitor-centred and elderly person-centred summaries:

QUESTION NUMBER	PRECEDENCE ORDER OF POSSIBLE ANSWERS
Q.1 for each activity	1. Yes - regularly 2. Yes - not regularly 3. No.
Q.2 for each service	1. Arranged new service 2. Arranged improvement of, or resumption of service. 3. Other queries. 4. No contact.
- for each appointment	1. Made appointment 2. Changed appointment 3. Other contact 4. No contact.
Q.3 for each professional worker	1. Yes 2. No.
Q.4	1. Yes 2. No.
Q.5 for each friend, neighbour or relative quoted	1. Contact relating to a specific purpose 2. Contact when no answer at door 3. Chance contact.
Q.6 for each friend or relative of a Project visitor introduced	1. Has visited regularly independently 2. Has undertaken specific tasks 3. Has visited alone 4. Has visited with Project visitor.

(Q.6 (4) was not analysed)

Q.7 (i) Precedence to most frequent visiting. With the exception that in ELDERLY PERSON-CENTRED SUMMARIES only, where two or more people were visiting concurrently, for some time, their number of visits each week were added together. No similar addition was done in visitor-centred summaries where visitors attended two or more old people concurrently.

No reference has been made above to data which is itself a summary: for example, the activity scores of visitors, the total number of contacts of various forms established, and the total numbers of introductions made. Where a question demanded internal summary in this way, and the data for that question was to be summarised from several completed questionnaires, the latter summary was performed first, and then the summary demanded by the question itself. With thought, some of the consequences of this technique will be apparent: in the ELDERLY PERSON-CENTRED SUMMARIES, whether one or more visitors have undertaken a particular action, this is recorded identically. This reflects, for example, the fact that two visitors, shopping once a week each, is no more valuable than one visitor shopping twice weekly. If two visitors have each met a different neighbour of an old person, this is recorded as two contacts; if two visitors have met the same neighbour, this is recorded as one contact. If two visitors each introduce a friend, this counts as two introductions (unless they both introduce the same person!)

In the VISITOR-CENTRED SUMMARIES, an activity is recorded identically whether performed for one or more elderly person. If a visitor introduces two friends to two old people, one to each, this is recorded as two introductions; if he introduces the same friend to two old people this counts as one introduction. If a visitor meets a neighbout of each of two old people, this is recorded as two contacts (unless those two neighbours are the same person!)

1. See Section 4.3 for results.
2. Reasons for not completing these 19 questionnaires had been: Project visitor insufficiently involved (8) - including 2 old people in hospital continuously since referral; Project visitor withdrawn previous to May 1972 (9); Project visitor placed with old person after completion of 50th questionnaire (2).
3. The results of these are presented in Ch.3.
4. The results of these are presented in Ch.4.

Appendix C. THE QUESTIONAIRES

C.1 THE QUESTIONNAIRES TO ELDERLY PEOPLE

Questions labelled * were only asked of those receiving ongoing help.

Name: Date of interview:
Address: Age:

1. Do you live alone? YES NO
   If NO, indicate household composition: .....
   .....

2. (1) What other relatives do you have living in the city? (record by household and identify by closest relative)

	Relationship to informant	Sex	Which part of the city does he/she live in?	Is he/she at work all day?
(i)				
(ii)				
(iii)				
(iv)				

   (2) Do any of your relatives own a car? YES NO

3. Indicate nature of accommodation in both (i) and (ii) below:

   (i) flatlet - shared facilities
   tenement flat
   terraced flat - upstairs
   terraced flat - downstairs
   modern flat - high rise, etc.
   terraced house
   semi-detached house
   bungalow

   (ii) owner-occupier
   council tenant
   private landlord

4. Do you have a Home Help? YES NO

   If NO, (1) Are you on the waiting list for one? YES NO
   (2) Have you ever had a Home Help? YES NO
   If YES why do you no longer have one?
   .....
   (3) Do you feel that you need a Home Help? YES NO

   If YES, (1) When does she come? Mon Tues Wed Thur Fri Sat Sun
   (2) Do you find that this is enough help? YES NO
   (3) How long have you had a Home Help for? ..... years
   (4) How many Home Helps have you had altogether, apart from very temporary ones? .....
   (5) How did you first come to get a Home Help? .....
   .....

4. YES cont'd.

(6) Does your Home Help take away anything to do for you in her own time? (specify) .....

(7) Does your Home Help come to you at all during her own time? YES NO

(8) Did you know Mrs. ..... before she became your Home Help? YES NO

5. Do you have Meals on Wheels? YES NO

If NO, (1) Are you on the waiting list for them? YES NO

(2) Have you ever had Meals on Wheels? YES NO

If YES, why do you no longer have them?

.....

If , (1) On which days do you get them?

Mon Tues Wed Thurs Fri Sat Sun

(2)* How long have you had meals on Wheels for? .....

(3)* Who arranged for you to have Meals on Wheels?

.....

(4) Do you find that this is often enough? YES NO

6. Is there a District Nurse calling regularly? YES NO

If , on which days does she come?

Mon Tues Wed Thurs Fri Sat Sun

7. Does anyone come to help you bath? YES NO

If NO, do you need someone to help you bath? YES NO

If YES, * who arranged this for you? .....

8. Does anyone come to help you dress? YES NO

If NO, do you need someone to help you dress? YES NO

If YES, * who arranged this for you? .....

9. Do you have your feet seen to by a chiropodist? YES NO

If NO, do you need to have your feet seen to by a Chiropodist? YES NO

If YES, (1) Do you (i) go to a clinic for treatment (and how)?

or (ii) have home visits from the Chiropodist?

(2) * How often do you receive treatment? .....

(3) * Who arranged it for you? .....

10. (i) Do you have books brought to you by the door-to-door library service? YES NO

If NO, would you like to receive this service? YES NO

If YES, who arranged this for you? .....

10. (cont'd)

(ii) Is there any other regular treatment or service that you get, which you haven't mentioned, such as regular appointments at hospital?

YES NO

If YES, give details: .....

11. Are you able to ...

	YES	WITH DIFFICULTY OR SUPERVISION	NO
(1) Walk outside?			
(2) Get around the house?			
(3) Get up and down stairs?			
(4) Do light housework?			
(5) Prepare a hot meal?			
(6) Make a cup of tea?			
(7) Dress yourself?			
(8) Wash your hands and face?			
(9) Have an all-over wash? (or bath yourself, if a bath is used)			
(10) Cut your own toenails?			
(11) Get to and use the toilet?			

12. (a) Who is there that calls in on you regularly, that is, at least once a week?

(i) .....
(ii) .....
(iii) .....
(iv) .....
(v) .....
(vi) .....
(vii) .....

(housemates are counted as visitors for the purpose of this question, as are Home Helps, but Meals on Wheels deliverers are too brief in their visits to justify inclusion)

(b) Who is there that you call in on fairly regularly? (once a week)

(i) .....
(ii) .....
(iii) .....
(iv) .....
(v) .....

(a) For each visitor recorded, ask:

(1) Does he/she live in this street? YES NO

(2) About how many days a week does he/she usually come in?
1 2 3 4 5 6 7

(3) When was the last time he/she came in?
1 2 3 4 5 6 7 days 1 - 2 weeks over 2 weeks ago

Now what do they do when they call?.....

(4) Has he/she done any shopping for you for a while?

YES NO

12. (cont'd)

If YES, when was the last time he/she did any shopping for you ?
1 2 3 4 5 6 7 days 1-2 weeks over 2 weeks ago

(5) Has he/she cooked a meal for you for a while ? YES NO
If YES, when was the last time he/she cooked something for you ?
1 2 3 4 5 6 7 days 1-2 weeks over 2 weeks ago

(6) Has he/she lit the fire for you for a while ? YES NO
If YES, when was the last time he/she lit the fire for you ?
1 2 3 4 5 6 7 days 1-2 weeks over 2 weeks ago

(7) Has he/she brought any coal in for you for a while ? YES NO
If YES, when was the last time he/she brough any coal in ?
1 2 3 4 5 6 7 days 1-2 weeks over 2 weeks ago

(8) Hos long have you known him/her, to talk to ?
Less than a year 1 - 5 5 - 10 10 - 20 over 20 years

** (9) How did you first get to know each other ?

** (10) Was there anything in particular which happened that made you get to know each other better, or which made you see more of each other ?

** (11) Did you ever used to go anywhere together ?

(12) Have you ever been in his/her home ? YES NO

(13) If YES to (4), (a) Has he/she always done the shopping for you, ever since you first knew each other ?
YES NO
If NO, ** How did he/she come to start doing the shopping ?

If YES to (5), (a) Has he/she always cooked a meal for you, ever since you first knew each other ?
YES NO
If NO, ** How did he/she come to start cooking a meal for you ?

If YES to (6), (a) Has he/she always made the fire for you, ever since you first knew each other ?
YES NO
If NO, ** How did he/she first come to start making the fire for you ?

(14) (i) Is she married ? MARRIED WIDOWED DIVORCED/SEP. SINGLE
(ii) Is she on a pension ? YES NO
(iii) Does she work at all ? FULL-TIME PART-TIME NONE

12 (c) Do you do any shopping yourself ? YES NO

If YES, when was the last time you did any shopping ?
1 2 3 4 5 6 7 days over 2 weeks

** These questions are open-ended and answers should be written on a separate sheet.

12 (c) (cont'd)

Have you done any cooking yourself for a while? YES NO
If YES, when was the last time you cooked a meal?

1 2 3 4 5 6 7 days 1 - 2 weeks over 2 weeks.

Have you lit the fire yourself for a while? YES NO
If YES, when was the last time you lit the fire yourself?

1 2 3 4 5 6 7 days. 1 - 2 weeks over 2 weeks.

Have you brought any coal in yourself for a while? YES NO
If YES, when was the last time you brought any coal in?

1 2 3 4 5 6 7 days 1 - 2 weeks over 2 weeks.

12 (b) Ask for each person visited by the respondent:

(1) Does he/she live in this street ? YES NO

(2) About how many days a week do you usually drop in to see them? 1 2 3 4 5 6 7 days.

(3) When was the last time you called on them?
1 2 3 4 5 6 7 days 1 - 2 weeks over 2 weeks.

13.* (i) (1) Who usually collects your pension?

.....

(2) Who collects it if he/she is unable to?

.....

(ii) (1) What do you do about your washing? done at home?
at launderette?

If it's done at home, who usually does it?

.....

If it's done at the launderette, who usually takes it?

.....

(iii) (1) Who usually collects your prescriptions for you?

.....

(2) Who collects it if they are unable to?

.....

13. (cont'd)

(iv) (1) What do you do about buying large things like clothing?

.....

14. You have told me of various ways in which your friends, neighbours and relatives help out; can you tell me about any ways in which you do things for others; for example, do you do any of the following:-

(i)	Babysit for any friends, neighbours or relatives?	YES	NO
(ii)	Prepare a meal for, say, a working relative?	YES	NO
(iii)	Knit for any of your younger grandchildren?	YES	NO
(iv)	Take in parcels for your neighbours?	YES	NO
(v)	Take in groceries for your neighbours from delivery men?	YES	NO
(vi)	Are there any other things you do for people you know?		

.....

.....

Now I'd like to ask you about some of the ways you spend your time at home:-

15. (i) Do you have a radio? YES NO
If YES, do you usually listen to it? YES NO

(ii) Do you have a television? YES NO
If YES, is it working? YES NO

(iii) Do you read books or magazines? YES NO

(iv) Do you do any knitting or embroidery? YES NO

(v) Is there anything else? .....

.....

16. Do you attend a luncheon club? YES NO
If YES, (i) How many days a week do you go? .....
(ii)* How do you get there? .....

If NO, *would you like to go to a luncheon club? YES NO

17. Do you go to an over-60's club? YES NO
If YES, (i) How many days a week do you go? .....
(ii)* How do you get there? .....

If NO, *would you like to go to a luncheon club? YES NO

18. Do you attend a Day Centre? YES NO

19. Do you ever go to Bingo? YES NO

*If YES, (i) When was the last time you went? .....

(ii) How do you usually get there? .....

If NO, would you like to go to Bingo? YES NO

20. Do you ever go to the cinema? YES NO

*If YES, (i) When was the last time you went? .....

(ii) How did you get there? .....

*If NO, would you like to go sometimes? YES NO

21. Do you ever go to church? YES NO

*If YES, (i) When was the last time you went? .....

(ii) How did you get there? .....

*If NO, (i) When was the last time you were visited by someone from the church? .....

(ii) Would you like to go to church sometimes? .....

22. Do you ever go to the pub? YES NO

*If YES, (i) When was the last time you went? .....

(ii) How do you usually get there? .....

*If NO, would you like to be able to go to the pub? YES NO

23. Do you ever sit in the park when the weather is fine? YES NO

*If YES, How do you get to the park? .....

*If NO, would you like to go to the park sometimes? YES NO

24. Do you have a regular annual holiday? YES NO

If YES, do you take this: Alone,

either staying with relatives or going away With relatives**

With an organised group

25.* Do you have your own teeth? YES NO

If YES, (i) When was the last time you visited a dentist? .....

(ii) How did you get there? .....

(iii) Who arranged your appointment? .....

If NO, do you own dentures? YES NO

If YES, do you wear them? YES NO

Are you wanting an appointment with the dentist? YES NO

26. (i) Do you own glasses? YES NO

*If YES, do you wear them: All the time

For reading etc.

Not at all

26. (cont'd)

(ii) When did you last have your eyes tested? .....

(iii)* Last time you had your eyes tested,
(1) How did you get there? .....
(2) Who made the appointment? .....

(iv)* Are you wanting an appointment with the optician? YES NO

(v) Can you read this typed sheet? YES With difficulty NO

27 Note whether the informant is having difficulty in hearing YES NO
If YES, *note whether he or she is wearing a hearing aid YES NO

Do you own a hearing aid? YES NO
*If YES, but he or she is not wearing it, ask why it is not worn:

.....

*If NO, would you like to see about getting a hearing aid? YES NO

28. (i) Who is your doctor? .....

(ii) When did you last see your doctor? .....

(iii)* Was this at home or in his surgery? .....

Who made the appointment? .....

(iv)* How do you usually get to the surgery if necessary .....
.....

(v) Does your doctor call at home regularly
without being asked to? YES NO
If YES, how often does he call? .....

29. Do you have a Health Visitor call? YES NO
If YES, (i) What is her name? .....

(ii) When was the last time he or she called? .....

30 Do you have a Social Worker call? YES NO
If YES, (i) What is his or her name? .....

(ii)* When was the last time he or she called? .....

31 (i) Do you draw an accupational pension? YES NO

(ii) Do you have a supplementary pension? YES NO

(iii)* Have you ever had a grant from the Social Security for such things as bedding and clothing? YES NO

(iv)* Do you think you need such a grant? YES NO

32. (i) How long have you lived here ? .....

(ii) Are you happy here or do you want to be rehoused ? YES NO

* If YES, have you applied to the Housing Department ? YES NO

If YES, when did you last hear from them ? .....

33. Are you Married Widowed Divorced/Separated Single ?

C2: THE FOLLOW-UP QUESTIONNAIRE TO ELDERLY PEOPLE RECEIVING ONGOING HELP.

Destination of elderly contact

0 Still at home, address unchanged.
1 Died
2 Entered long-stay hospital
3 Entered residential home
4 Moved in with relatives
5 Rehoused (no change in household composition)
6 entered supervised accomm.

Completion of questionnaire

0 Questionnaire completed
1 Refused to complete Q.
2 Not done -- human reasons
3 personality problems would render Q unreliable.
4 Too confused.
5 unable to communicate - - deaf or aphasic
6 volunteer insufficiently involved.

Note any change in household composition : .....

.....

.....

Does a HEP visitor still call?

0 No
1 Yes - at least once a week
2 Yes - less often

Level of provision of Home Help

0 No change in level of provision
1 Home Help hours increased
2 Home Help hours decreased
3 Home Help newly arranged
4 Home Help newly withdrawn

Level of provision of Meals on Wheels

0 No change
1 Increased
2 Decreased
3 Arranged
4 Withdrawn

New services arranged - and by whom

0 Self
1 housemate
2 relative
3 friend, neighbour or H.H.
4 HEP
5 professional worker
8 not applicable

☐ Home Help
☐ Meals on Wheels
☐ District Nurse
☐ Bath attendant
☐ Chiropody
☐ Door-to-door library service

Visitors who call at least once a week (listed on the original questionnaire administered to this person)

☐ (i)
☐ (ii)
☐ (iii)
☐ (iv)
☐ (v)
☐ (vi)
☐ (vii)

Code: 0 No change - still calls at least once at least once a week
1 calls less than weekly now
2 no longer calls at all

In the case of 1 or 2 note any reasons given for loss of involvement by a visitor:

.....

.....

.....

.....

New visitors

List any new visitors indicating category:

☐ (i) .....

☐ (ii) .....

☐ (iii) .....

☐ (iv) .....

1 New housemate
2 relative
3 friend, neighbour or H.H.
4 HEP visitor

☐ (v) .....

☐ (vi) .....

Changes in the pattern of social activities

0 No change
1 No attendance before - now attends club (or day centre or day care)
2 attended before - now attends more clubs
3 attended before - now attends less clubs or no clubs.

C3: THE POSTAL QUESTIONNAIRE TO VISITORS

PART ONE

1. What is your date of birth? .....

2. What is your full name? .....

3. Are you: Single Married Widowed Divorced/Separated

4. If you have children, either young or adult, list how many below:

number under school age :- .....
number of school age:- .....
number who have left school
but still live at home:- .....
number who have now left home:- .....

TOTAL NO. OF CHILDREN: _____

5. Are you :- (tick one of the following)
Working full-time
Working part-time
Not Working
Retired
College Student
School Pupil

6. (a) If you are working, either full-time or part-time, give full details of your work:

.....

.....

(b) If you are not working at present, have you had either a part-time or full-time job within the last five years:-

YES NO

7. If you are a married woman, please give details of your husband's occupation:

.....

The remaining questions are about other activities you may be engaged in:

8. Do you go regularly to any clubs or meetings? YES NO
If you do, please give details:

.....

.....

.....

.....

9. Are there any activities which you organise or help to run ? YES NO
If you do, please give details:

.....

.....

.....

10. Do you go to a church regularly ? YES NO

11. Do you go out for the evening regularly with others, for example to a local social club or local pub ? YES NO

12. (a) Had you ever done any 'organised' visiting of elderly people before joining this Project ? YES NO

(b) Are you presently doing any 'organised' visiting of the elderly other than those you are visit through this Project ? YES NO

QUESTIONNAIRE - PART TWO

(COMPLETED ON BEHALF OF EACH ELDERLY PERSON VISITED THROUGH THE PROJECT)

Please think back hard and answer each of the following questions with reference to:-

.....

.....

1. Have you ever done any of the following for him/her ? Please tick anything you have ever done for him/her:-

MESSAGES, Etc.

- ☐ shopping
- ☐ collected pension
- ☐ collected prescription
- ☐ taken washing to launderette
- ☐ bought a special item - anything from town, for example.
- ☐ other .....

ESCORTING, Etc.

- ☐ Pushed him/her out in wheelchair
- ☐ escorted him/her to shops
- ☐ escorted him/her to a friend's etc.
- ☐ escorted him/her to a club
- ☐ escorted him/her to an appointment (e.g. at doctor's, hospital, optician, chiropodist, dentist, etc.)

WITHIN THE HOUSE:

- ☐ Lit fire
- ☐ Brought coals in
- ☐ cooked meal in his/her home
- ☐ taken along a meal from your own ho
- ☐ opened tins of food or soup etc.
- ☐ taken a present of food
- ☐ done ironing
- ☐ done light housework
- ☐ made a cup of tea
- ☐ washed up dished

- ☐ driven him/her to shops
- ☐ driven him/her to friends etc.
- ☐ driven him/her to club
- ☐ driven him/her to appointment
- ☐ driven him/her elsewhere
- ☐ visited him/her in hospital
- ☐ visited while he/she was on holiday or in convalescence
- ☐ visited him/her on Christmas day
- ☐ brought him/her into your own home

READING AND WRITING

- ☐ collected library books
- ☐ taken along books or magazines
- ☐ read a letter out loud because he/she
- ☐ sent him/her a Christmas card
- ☐ written to him/her while you were unable to visit.

read a letter out loud because he/she couldn't see to read it

written a letter for him/her because he/she can't write

OTHER THINGS YO U HAVE DONE FOR HIM/HER .....

.....

2. Have you ever made enquiries of any kind connected with any of the following, on behalf of him/her ? (either to HEP or to any official person. This includes requesting services, making appointments, as well as clarifying arrangements, asking about

(Tick in the appropriate boxes).

- ☐ Home Help
- ☐ Meals on Wheels
- ☐ Chiropodist
- ☐ Bath Attendant
- ☐ Door-to-door library service
- ☐ Luncheon Club
- ☐ Over-60's Club
- ☐ Other: .....
- ☐ Appointment at hospital out-patients
- ☐ Appointment at opticians
- ☐ Appointment at dentists
- ☐ Appointment elsewhere .....

3. Have you ever been in contact with his/her: (including by telephone or letter) (tick)

- ☐ Doctor
- ☐ Health Visitor
- ☐ Social Worker
- ☐ Medical Social Worker (Lady Almoner)
- ☐ Hospital Sister

4. Have you ever met his/her Home Help ? YES NO

5. Have you ever had contact with any of his/her friends or neighbours or relatives who visit, either through meeting them or on the telephone or by letter ?

YES NO

If you have, list them below, starting with those you have had most contact with:-

(i) .....

(ii) .....

(iii) .....

6. Is there anyone who hadn't met him/her before and first met him/her through you ?

(including your own family and friends)

YES NO

If you have introduced anyone else in this way, please list them below:-

(i) .....

(ii) .....

(iii) .....

QUESTIONNAIRE TO VISITORS

C4 : THE FOLLOW-UP INTERVIEW WITH VISITORS (Question numbers refer to the postal Questionnaire)

Visitor Index No:..... Name:.....

PART ONE

1,2,3,4,5,: - -

6. If not working or retired, establish previous occupation (except in the case of a married woman);

.....

7. (If visitor is a married woman) If husband is not working or retired, establish previous occupation;

.....

8.- 13: - -

14. Are there any other elderly people, other than any whom you visit through the Project, who you visit at home at least once a week?
(This includes relatives, friends and neighbours).

YES NO

If YES, list them:- (i) .....

(ii) .....

(iii) .....

(iv) .....

(v) .....

(vi) .....

Then ask the questions overleaf.

15. Are there any other elderly people you have known in the past, whom you have visited regularly at least once a week?
(Including relatives, friends and neighbours)

YES NO

If YES, list them:- (i) .....

(ii) .....

15. (cont'd)

(iii) .....

(iv) .....

(v) .....

(vi) .....

For each person listed in question 14, ask:

(1) Do you do anything practical for him/her, such as shopping, cooking, lighting the fire, providing transport?

YES NO

If YES, specify .....

.....

(2) How long have you known him/her to talk to, that is (ring)

Less than 1 year 1 - 5 years 5 - 10 years 10 - 20 years over 20

(3) How did you get to know him/her? .....

.....

(4) For how long have you visited regularly at least once a week?

.....

(5) Have you done shopping right from the start?

YES NO

If NO, how did you come to start doing the shopping?

.....

For each person listed in Question 15, ask:

(1) For how long did you visit him/her regularly at least once a week?

.....

(2) Did you used to do anything practical for him/her such as shopping, lighting the fire, cooking or providing transport?

YES NO

If YES, specify .....

.....

(3) How did you get to know him/her? .....

.....

16. (i) Have you ever contacted any servicesor made any appointments on behalf of any elderly person (other than your HEP friend) since..... when you joined the Project?
e.g. anyone in (14) above. YES NO

(ii) Have you ever been in contact with a doctor/HV/SW/MSW/Hospital Sister on behalf of any elderly person other than your HEP friend since ..... when you joined the Project?
YES NO

17. (i) Have you ever contacted any services or made any appointments on behalf of any elderly person (other than your HEP friend) previous to joining the Project?
e.g. anyone in (15) above.
YES NO

(ii) Have you ever been in contact with a doctor/HV/SW/MSW/Hospital Sister on behalf on any elderly person previous to joining the Project?
YES NO

18. There are some things which friends, neighbours and organised visitors can reasonably be expected to do for elderly people; there are other things which are best done by paid and often trained workers or through help provided by the state. Which of the following things do you feel it is <u>not</u> reasonable to expect friends, neighbours and organised visitors to do?

(ongoing)	shopping	arranging services
	giving a bath	housework
	cooking meals	dressing
	making the fire	help at the toilet
	washing clothes	collecting pension
	applying medicaments	pushing out in wheelchair
	'granny-minding'	ensuring she takes medicines

(one-off) packing prior to moving; laying lino; providing transport to appointments; providing transport to visit relatives in hospital; cleaning out a filthy house; escorting to a shopping trip in town; visiting daily while a helping neighbour is on holiday; cutting hair; giving home perm; cleaning up an overgrown garden; negotiating for DHSS grant; decorating a room.

19 In the case of an old person who needed <u>a lot</u> or care, i.e. lighting the fire in the morning, cooking lunch and team shopping and locking up at night - what is the most often that you would be ready to visit if she was living close nearby?

.....

20. Which of the two following statements do you feel is nearest the truth?

20. (cont'd)

(a) I have not done anything through being involved in HEP which I would not have done anyway if I had already known of that person in need. What the Project has done is to tell me about that person and how I could help.

(b) HEP has led me to discover ways in which I can help old people which I would not otherwise have thought of ; it has enabled me to do things which it would not have occurred to me to do.

QUESTIONNAIRE TO VISITORS

PART TWO (follow-up interview)
(completed on behalf of each elderly person visited through the Project)

Visitor index No:..... Index No. of elderly contact:.....

Name:.....

1. Explore any other things which the visitor may have done which is not show on the list provided.

   Ask which of the items listed have been done regularly?
   (i.e. at least once a month). Underline those things done regularly.

2. For each of the contacts indicated, establish the nature and purpose of the contact.

SERVICE	NATURE/PURPOSE OF CONTACT
(i)	.....
(ii)	.....
(iii)	.....
(iv)	.....
(v)	.....
(vi)	.....

3. For each of the contacts indicated, establish the nature and prupose of the contact.

OFFICIAL	NATURE/PURPOSE OF CONTACT
(i)	.....
(ii)	.....
(iii)	.....
(iv)	.....
(v)	.....

4.-

5. Ask for each person indicated in Question 5 of the Postal Questionnaire to visitors :-

(1) Have you ever met hime/her personally? YES NO

(2) Have you ever contacted him/her for some reason connected with the person you are visiting? YES NO

If YES, give details: .....

.....

.....

(3) Has he/she ever contacted you for some reason connected with the person you are visiting? YES NO

If YES, give details: .....

.....

.....

(4) How did you first make contact with him/her?

.....

.....

.....

Ask for each person indicated in Question 6 of the Postal Questionnaire :-

6. (i) What has been the nature of his/her involvement?

.....

.....

(ii) .....

.....

(iii) .....

.....

7. (i) How often did you visit/have you been visiting him/her usually?

.....

(ii) If there has been a special period when you visited him/her more often than usual, when was this?

.....

.....

7 (cont'd)

and how often were you visiting at this time? .....

.....

NOTES

7 DEC 1974